

11416 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY AA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Glen Burnie	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 403 Joyce Drive		d. STREET ADDRESS 403 Joyce Drive	
3. NAME OF DECEASED (Type or print) First Mary Middle Elizabeth Last Armager		4. DATE OF DEATH Month Nov. Day 10 Year 1957	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 12, 1876
9. AGE (In years last birthday) yrs. 80		IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS.: Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jefferson M. Cook		14. MOTHER'S MAIDEN NAME Emma Linstid	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 6-----	
17. INFORMANT Wm. L. Armager, Riviera Beach, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Acute bronchopneumonia DUE TO (b) Cerebro-vascular accident DUE TO (c) arteriosclerotic cerebro-vascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 4 days 2 years not determined	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 491X none		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 20, 1954 , to November 10, 1957 , that I last saw the deceased alive on November 9, 1957 , and that death occurred at 10:44 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE R. M. McLaughlin		DATE SIGNED Nov. 10, 1957	
PHYSICIAN'S NAME (Type) James E. Hopping		ADDRESS Passadena, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 13, 57	22c. NAME OF CEMETERY OR CREMATORY Mt. Carmel	22d. LOCATION (City, town, or county) (State) Anne Arundel, Md.
23. FUNERAL DIRECTOR'S SIGNATURE James E. Hopping		24a. REC'D BY REGISTRAR Nov 13 1957	
ADDRESS Hopping & Kirkley, Glen Burnie, Md.		24b. REGISTRAR'S SIGNATURE L. J. DeAlby	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 will be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 13 1961

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Reg. Dist. No.

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11406

Reg. Dist. No. 28

11418

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville, Md.</u>		c. LENGTH OF STAY IN 1b <u>6 mo, 1 day</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital, Md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>OAKLEY</u> Middle <u>BALL</u> Last <u>BALL</u>		4. DATE OF DEATH Month <u>11</u> Day <u>17</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 21, 1895</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		9b. AGE (In years last birthday) <u>62</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Joe Ball</u>		14. MOTHER'S MAIDEN NAME <u>Bertha</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>W. W. I</u>	
17. INFORMANT <u>Hospital Records</u>		Address _____	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Insufficiency</u> <u>420.1</u> DUE TO <u>Myocardial Fibrosis and Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) <u>Coronary Arteriosclerosis</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Hemorrhage</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour <u>o. p.</u> <u>-----</u> 19 <u>-----</u> p. m. <u>-----</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>May 16</u> , 19 <u>57</u> , to <u>November 17</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>November 17</u> , 19 <u>57</u> , and that death occurred at <u>11:05 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Ludwig Benedict</u> M.D. <u>Crownsville, Md.</u> <u>11/18/57</u> PHYSICIAN'S NAME (Type) <u>Ludwig Benedict, M. D.</u> <u>Crownsville State Hospital, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11/22/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>BALTIMORE NATIONAL</u>		22d. LOCATION (City, town, or county) _____ (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles R. Law</u>		24a. REC'D BY REGISTRAR <u>NOV 22 1957</u>	
ADDRESS <u>802 Madison Ave</u>		24b. REGISTRAR'S SIGNATURE <u>Katherine Joyce</u>	

BUREAU V. S.

NOV 22 1957

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The body copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11407

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH COUNTY <u>Anne Arundel</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Glen Burnie 1 wk</u> TOWN <u>1 wk</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sonn Nursing Home</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md</u> COUNTY <u>Anne Arundel</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Northwood Heights</u> TOWN <u>1</u> STREET ADDRESS (If rural give location) <u>114 S. Camp Meade Rd.</u>			
3. NAME OF DECEASED (Type or Print) <u>AUGUST</u> (First) <u>F</u> (Middle) <u>BECKER</u> (Last)				4. DATE OF DEATH (Month) <u>Nov</u> (Day) <u>24</u> (Year) <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Wid.</u>	8. DATE OF BIRTH <u>Dec 23, 1873</u>	9. AGE last birthday <u>83</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hardwood Worker</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <u>William Becker</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>705-53-5365</u>		17. INFORMANT & ADDRESS <u>Nursing Home</u>		
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 332X IMMEDIATE CAUSE (A) <u>Bronchopneumonia</u>						7 days	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cerebral Thrombosis</u>						9 days	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>491X</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov 22, 1957</u> , to <u>Nov 24, 1957</u> , that I last saw the deceased alive on <u>Nov 22, 1957</u> , and that death occurred at <u>10:30 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>C. Milton Luthien</u> M.D.				DATE SIGNED <u>11/24/57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>11-26-1957</u>		NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>		LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
24. REC'D BY REGISTRAR <u>NOV 26 1957</u>		REGISTRAR'S SIGNATURE <u>L. J. Adlman</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>G. Howard Strong</u>		ADDRESS <u>3207 W. North Ave.</u>	

CERTIFICATE OF DEATH

Form 100, 1957

1. NAME OF DECEASED (Print or Type)

2. SEX
3. AGE

4. PLACE OF BIRTH

5. DATE OF BIRTH

6. PLACE OF DEATH

7. CAUSE OF DEATH (List all causes, beginning with the immediate cause, and giving the underlying cause last)

8. MANNER OF DEATH (Natural, Accidental, Suicide, Homicide, Undetermined)

9. PLACE OF DEATH (Home, Hospital, Nursing Home, etc.)

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. SIGNATURE OF FUNERAL HOME

15. SIGNATURE OF OTHER

16. SIGNATURE OF OTHER

17. SIGNATURE OF OTHER

18. SIGNATURE OF OTHER

19. SIGNATURE OF OTHER

20. SIGNATURE OF OTHER

21. SIGNATURE OF OTHER

22. SIGNATURE OF OTHER

23. SIGNATURE OF OTHER

24. SIGNATURE OF OTHER

25. SIGNATURE OF OTHER

26. SIGNATURE OF OTHER

27. SIGNATURE OF OTHER

28. SIGNATURE OF OTHER

29. SIGNATURE OF OTHER

30. SIGNATURE OF OTHER

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NOV 26 1957

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11420
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A. A. Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>A. A. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL</u>		c. LENGTH OF STAY IN 1b <u>15 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Earleish Heights</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Edna Louise Bell</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>30</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-24-1901</u>
9. AGE (In years last birthday) <u>56</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>Lewis W. Jeffries</u>	
14. MOTHER'S MAIDEN NAME <u>Annie B. Jones</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Charles W. Bell - Severna Park</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>18 mos</u> <u>3 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260x Diabetes Mellitus</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Nov 30</u> , 19 <u>57</u> , to <u>Nov 30</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Nov 30</u> , 19 <u>57</u> , and that death occurred at <u>11:35 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Faye W. Allen</u>		DATE SIGNED <u>12-2-57</u>	
PHYSICIAN'S NAME (Type) <u>Faye W. Allen</u>		ADDRESS (Street, city or town, state) <u>62 Cathedral St Annapolis Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>12-4-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Silas Baptists</u>	22d. LOCATION (City, town, or county) (State) <u>Earleish Heights Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Hicks III</u>		24. REC'D BY REGISTRAR <u>12/3/57</u>	
ADDRESS <u>Annapolis-Md</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

See Part 1a

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. DATE OF DEATH		7. PLACE OF BIRTH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
JAMES EARL RAY		M		35		W		10-1-28		4-4-68		MEMPHIS, TENN		MEMPHIS, TENN		HEART DISEASE		NATURAL		JAMES EARL RAY		JAMES EARL RAY	
13. OCCUPATION		14. EDUCATION		15. MARITAL STATUS		16. RELIGION		17. PREVIOUS ILLNESS		18. PREVIOUS SURGERY		19. PREVIOUS TRAUMA		20. PREVIOUS DRUGS		21. PREVIOUS ALCOHOL		22. PREVIOUS TOBACCO		23. PREVIOUS OTHER		24. PREVIOUS OTHER	
ATTORNEY		HIGH SCHOOL		MARRIED		METHODIST		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE	
25. SIGNATURE OF WITNESS		26. SIGNATURE OF WITNESS		27. SIGNATURE OF WITNESS		28. SIGNATURE OF WITNESS		29. SIGNATURE OF WITNESS		30. SIGNATURE OF WITNESS		31. SIGNATURE OF WITNESS		32. SIGNATURE OF WITNESS		33. SIGNATURE OF WITNESS		34. SIGNATURE OF WITNESS		35. SIGNATURE OF WITNESS		36. SIGNATURE OF WITNESS	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	

BUREAU V. S.

DEC 5 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE M.D. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville, Md.		c. LENGTH OF STAY IN 1b 4 mo. 11 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Geneva Middle Last Brady		4. DATE OF DEATH Month 11 Day 1 Year 19 57	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/24/14
9. AGE (In years last birthday) 43 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James Brady		14. MOTHER'S MAIDEN NAME Mary Lewis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Pneumonia 352x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Tetraplegia flaccid (c) Fracture dislocation of 6th vertebra prior to 3/4/54 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) D cubitus Ulcer			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 21 , 19 57 to November 1 , 19 57 , that I last saw the deceased alive on November 1 , 19 57 , and that death occurred at 5:40a M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Lionel McHenry Mapp M.D. Crownsville, Md. 11/1/57			
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D. Crownsville State Hospital, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	11/1/57	mt Auburn CA	Balta City
23. FUNERAL DIRECTOR'S SIGNATURE Isaiah L. Brown		24a. REC'D BY REGISTRAR NOV 6 1957	
ADDRESS		24b. REGISTRAR'S SIGNATURE A. M. Joyce	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration information prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU A. 1.

NOV 9 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11411

11392 CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b x2 Annapolis			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Burnside Ave.				d. STREET ADDRESS Three Mile Oak			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First ROSE Middle EVA Last BRITTON				4. DATE OF DEATH Month Nov Day 13 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 26, 1892	9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Annapolis, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel W. Smith				14. MOTHER'S MAIDEN NAME Stella Brewer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 219-38-4948		17. INFORMANT Mr Alfred W. Britton Sr.-Son- same as # 1			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH 7 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cirrhosis of the liver							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Annapolis		(County) Maryland	(State) Md.
21. I certify that I attended the deceased from Sept , 1955, to Nov 12 , 1957, that I last saw the deceased alive on Nov 12 , 1957, and that death occurred at 3:30 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 90 Cathedral Street, Annapolis, Md. DATE SIGNED 11/13/57							
ACTUAL SIGNATURE John H. Hedeman				M.D.			
PHYSICIAN'S NAME (Type) JOHN HEDEMAN MD				90 Cathedral Street, Annapolis, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-16-57	22c. NAME OF CEMETERY OR CREMATORY Cedar Bluff Cemetery		22d. LOCATION (City, town, or county) (State) Annapolis, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home				ADDRESS Annapolis, Md.		24a. REC'D BY REGISTRAR Nov 18 1957	
				24b. REGISTRAR'S SIGNATURE Mr. French			

BUREAU V. S.

NOV 18 1957

RECEIVED

11422 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenburnie		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Glenburnie	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6118 Ritchie Highway		d. STREET ADDRESS 6118 Ritchie Highway	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First FRANCES Middle M Last BROOKS		4. DATE OF DEATH Month November Day 5 Year 19 57	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Meryland; Annie Arundel Co.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lawson Brooks		14. MOTHER'S MAIDEN NAME Coronus Taylor	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Evelyn Riddick		Address 2207 Liberty Heights Avenue	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) massive Internal Hemorrhage 540.0 DUE TO Gastric Ulcer Conditions, if any, which gave rise to immediate case (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 30 hrs. 3 weeks.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 15, 1956 to Nov. 4, 1957 , that I last saw the deceased alive on Nov. 4, 1957 , and that death occurred at 1200 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE P. J. Grimaldi		ADDRESS (Street, city or town, state) 4609 Gov. Ritchie Hwy	
PHYSICIAN'S NAME (Type) P. J. GRIMALDI		DATE SIGNED NOV 12 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 7, 1957	22c. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Park	22d. LOCATION (City, town, or county) (State) Arbutus, Anne Arundel Co. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Elroy O. Wilson		ADDRESS 1000 Brantley Avenue	
24a. REC'D BY REGISTRAR NOV 12 1957		24b. REGISTRAR'S SIGNATURE L. J. [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 5, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 6 and 7 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		MARRIAGE	
DATE OF DEATH		PLACE OF DEATH		CITY		COUNTY		STATE	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF BURIAL		PLACE OF BURIAL	
SIGNATURE OF PHYSICIAN		SIGNATURE OF MINISTER		SIGNATURE OF CORONER		SIGNATURE OF JURY		SIGNATURE OF DEPUTY CLERK	

Handwritten notes:
No. 1000
Date of death Nov 12 1907
Cause of death ...

BUREAU V. S.

NOV 12 1907

RECEIVED

Handwritten notes:
Nov 12 1907
J. J. ...
...

11393

CERTIFICATE OF DEATH

Reg. Dist. No.

21

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>C.C.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>10</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>15 Baileum Drive</u>				d. STREET ADDRESS <u>15 Baileum Drive</u>			
3. NAME OF DECEASED (Type or print) <u>John W. Brooks</u>				4. DATE OF DEATH <u>11 21 1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Col.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-2-1890</u>	
9. AGE (In years last birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Chaffeur</u>			
13. FATHER'S NAME <u>William H. Brooks</u>				14. MOTHER'S MAIDEN NAME <u>Fannie Brooks</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>7101</u>			
17. INFORMANT <u>Dorothy Brooks</u>				Address <u>Annapolis, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma / Stomach</u> 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11-20-57</u> , 19 <u>57</u> , to <u>11-21-57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11-21-57</u> , 19 <u>57</u> , and that death occurred at <u>11:55</u> M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>62 Cathedral St</u>				DATE SIGNED <u>11-21-57</u>			
ACTUAL SIGNATURE <u>A. T. Alfrey</u> M.D.							
PHYSICIAN'S NAME (Type) <u>A T ALFREY</u>				<u>62 Cathedral St</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>11-25-57</u>		<u>Carver Memorial</u>		<u>Laurel, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr.</u>				ADDRESS <u>Annapolis, Md.</u>			
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE		DATE <u>11/29/57</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

11414

Reg. Dist. No.

11423

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Broadwater Church</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Broadwater Churchton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION _____		d. STREET ADDRESS _____			
3. NAME OF DECEASED (Type or print) First <u>Guy</u> Middle _____ Last <u>Brosee</u>		4. DATE OF DEATH <u>NOVEMBER 2, 1957</u> Day _____ Year _____			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 22, 1882</u>		
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>7</u> Days <u>11</u> Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Govt. Printing Off. U.S. Govt.</u>		10b. KIND OF BUSINESS OR INDUSTRY _____			
11. BIRTHPLACE (State or foreign country) <u>MAYSVILLE, KENTUCKY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Charles E. Brosee</u>		14. MOTHER'S MAIDEN NAME <u>Emma Newdigat</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. _____			
17. INFORMANT Address <u>MRS. ROSE A. BROSEE - Broadwater, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO <u>Arterio sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Pulmonary Congestion</u> DUE TO <u>Chronic Pulmonary insufficiency</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u> <u>2+ years</u> <u>one week</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>December 19, 1956</u> to <u>November 19, 1957</u> , that I last saw the deceased alive on <u>November 19, 1957</u> , and that death occurred at <u>8:15 P.</u> M. from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>F.D. Hendricks</u> M.D.		ADDRESS (Street, city or town, state) <u>Shady Side, Maryland</u> DATE SIGNED <u>11/26/57</u>			
PHYSICIAN'S NAME (Type) <u>F.D. Hendricks</u>		ADDRESS <u>Shady Side, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>NOV. 6/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>SUITLAND, MARYLAND</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Martin W. Hysong</u>		ADDRESS <u>1300-N St. N.W. Wash. D.C.</u>			
24a. REC'D BY REGISTRAR <u>NOV 5 '57</u>		24b. REGISTRAR'S SIGNATURE <u>Quelch</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

NOVEMBER 21

MARCH 23, 1887

Charles E. Broose
Retired - Govt Printing Office
U.S.A. New York
Mrs. Rose A. Broose - Broadwater, Md.

BUREAU V. S.

NOV 5 1937

RECEIVED

Washington, D.C. 100-1124 N.W. West D.C.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 of this certificate shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11424

CERTIFICATE OF DEATH

11415

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Crownsville, MD</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Baltimore</u> b. COUNTY <u>NO. 2-2.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville, MD.</u>		c. LENGTH OF STAY IN 1b <u>years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u>		d. STREET ADDRESS <u>1. Box 417, Severna Park MD.</u>	
3. NAME OF DECEASED (Type or print) First <u>(EUGENE)</u> Middle <u>Thomas</u> Last <u>William Brown</u>		4. DATE OF DEATH Month <u>11</u> Day <u>10</u> Year <u>1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-13-1902</u>
9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Desinger</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Eugene Brown.</u>		14. MOTHER'S MAIDEN NAME <u>Della Brown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u> </u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>General arteriosclerosis</u> DUE TO (c) <u>Cerebrovascular arteriosclerosis</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8-26-1956</u> , to <u>11-10-1957</u> , that I last saw the deceased alive on <u>12</u> , and that death occurred at <u>7:30</u> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Crownsville State hospital 11/</u> DATE SIGNED <u> </u>			
ACTUAL SIGNATURE <u>L. Benedict</u> M.D.		PHYSICIAN'S NAME (Type) <u>L. Benedict MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-13-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Luke Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Reisterstown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles R. Law</u>		ADDRESS <u>802 Madison Avenue</u>	
24. REC'D BY REGISTRAR <u>NOV 14 1957</u>		24b. REGISTRAR'S SIGNATURE <u>R. M. Jones</u>	

CERTIFICATE OF DEATH

Form 10-1-56

1. NAME OF DECEASED [Illegible]		2. SEX [Illegible]		3. AGE [Illegible]		4. RACE [Illegible]		5. DATE OF BIRTH [Illegible]		6. PLACE OF BIRTH [Illegible]		7. MARITAL STATUS [Illegible]		8. OCCUPATION [Illegible]		9. CAUSE OF DEATH [Illegible]		10. MANNER OF DEATH [Illegible]		11. SIGNATURE OF DECEASED [Illegible]		12. SIGNATURE OF WITNESS [Illegible]		13. SIGNATURE OF PHYSICIAN [Illegible]		14. SIGNATURE OF CORONER [Illegible]		15. SIGNATURE OF JURY [Illegible]		16. SIGNATURE OF JUDGE [Illegible]		17. SIGNATURE OF CLERK [Illegible]		18. SIGNATURE OF REGISTRAR [Illegible]		19. SIGNATURE OF [Illegible]		20. SIGNATURE OF [Illegible]		21. SIGNATURE OF [Illegible]		22. SIGNATURE OF [Illegible]		23. SIGNATURE OF [Illegible]		24. SIGNATURE OF [Illegible]		25. SIGNATURE OF [Illegible]		26. SIGNATURE OF [Illegible]		27. SIGNATURE OF [Illegible]		28. SIGNATURE OF [Illegible]		29. SIGNATURE OF [Illegible]		30. SIGNATURE OF [Illegible]		31. SIGNATURE OF [Illegible]		32. SIGNATURE OF [Illegible]		33. SIGNATURE OF [Illegible]		34. SIGNATURE OF [Illegible]		35. SIGNATURE OF [Illegible]		36. SIGNATURE OF [Illegible]		37. SIGNATURE OF [Illegible]		38. SIGNATURE OF [Illegible]		39. SIGNATURE OF [Illegible]		40. SIGNATURE OF [Illegible]		41. SIGNATURE OF [Illegible]		42. SIGNATURE OF [Illegible]		43. SIGNATURE OF [Illegible]		44. SIGNATURE OF [Illegible]		45. SIGNATURE OF [Illegible]		46. SIGNATURE OF [Illegible]		47. SIGNATURE OF [Illegible]		48. SIGNATURE OF [Illegible]		49. SIGNATURE OF [Illegible]		50. SIGNATURE OF [Illegible]		51. SIGNATURE OF [Illegible]		52. SIGNATURE OF [Illegible]		53. SIGNATURE OF [Illegible]		54. SIGNATURE OF [Illegible]		55. SIGNATURE OF [Illegible]		56. SIGNATURE OF [Illegible]		57. SIGNATURE OF [Illegible]		58. SIGNATURE OF [Illegible]		59. SIGNATURE OF [Illegible]		60. SIGNATURE OF [Illegible]		61. SIGNATURE OF [Illegible]		62. SIGNATURE OF [Illegible]		63. SIGNATURE OF [Illegible]		64. SIGNATURE OF [Illegible]		65. SIGNATURE OF [Illegible]		66. SIGNATURE OF [Illegible]		67. SIGNATURE OF [Illegible]		68. SIGNATURE OF [Illegible]		69. SIGNATURE OF [Illegible]		70. SIGNATURE OF [Illegible]		71. SIGNATURE OF [Illegible]		72. SIGNATURE OF [Illegible]		73. SIGNATURE OF [Illegible]		74. SIGNATURE OF [Illegible]		75. SIGNATURE OF [Illegible]		76. SIGNATURE OF [Illegible]		77. SIGNATURE OF [Illegible]		78. SIGNATURE OF [Illegible]		79. SIGNATURE OF [Illegible]		80. SIGNATURE OF [Illegible]		81. SIGNATURE OF [Illegible]		82. SIGNATURE OF [Illegible]		83. SIGNATURE OF [Illegible]		84. SIGNATURE OF [Illegible]		85. SIGNATURE OF [Illegible]		86. SIGNATURE OF [Illegible]		87. SIGNATURE OF [Illegible]		88. SIGNATURE OF [Illegible]		89. SIGNATURE OF [Illegible]		90. SIGNATURE OF [Illegible]		91. SIGNATURE OF [Illegible]		92. SIGNATURE OF [Illegible]		93. SIGNATURE OF [Illegible]		94. SIGNATURE OF [Illegible]		95. SIGNATURE OF [Illegible]		96. SIGNATURE OF [Illegible]		97. SIGNATURE OF [Illegible]		98. SIGNATURE OF [Illegible]		99. SIGNATURE OF [Illegible]		100. SIGNATURE OF [Illegible]	
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BUREAU V. S.

NOV 14 1957

RECEIVED

[Handwritten signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11416

11394

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Annapolis, Md.				/ d. STREET ADDRESS Qtrs. A, Experimental Station			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First William Middle Wheeler Last BROWN				4. DATE OF DEATH Month November Day 19 Year 19 57			
5. SEX M	6. COLOR OR RACE Cau	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 17 July 1910		9. AGE (In years last birthday) 47 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Navy		10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy		11. BIRTHPLACE (State or foreign country) Tennessee		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Ralph W. Brown				14. MOTHER'S MAIDEN NAME Belva McCallie			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) WWII & Korea		17. INFORMANT U.S. Naval Hospital, Annapolis, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thrombosis Cerebral middle cerebral artery 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH 3 1/2 days							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 15 November, 1957 , to 19 November, 1957 , that I last saw the deceased alive on 19 November, 1957 , and that death occurred at 0915 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Thomas P. Connelly				ADDRESS (Street, city or town, state) U.S. Naval Hospital, Annapolis, Md.			
PHYSICIAN'S NAME (Type) T. P. CONNELLY				DATE SIGNED 11-19-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal-Burial				22b. DATE THEREOF 11/22/57		22c. NAME OF CEMETERY OR CREMATORY Thmalpias Cemetery	
22d. LOCATION (City, town, or county) San Rafael				(State) California			
23. FUNERAL DIRECTOR'S SIGNATURE HOPPING FUNERAL HOME				ADDRESS Annapolis, Maryland		24a. REC'D BY REGISTRAR 2257	
						24b. REGISTRAR'S SIGNATURE	

middle cerebral artery

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NOV 22 1957
BUREAU V. S.

BUREAU V. S.

NOV 22 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11417

Reg. Dist. No.

11425

FOR STATE
HEALTH DEPT.

M

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PASADENA R.F.D.</u>		c. LENGTH OF STAY IN 1b <u># YES.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Rt. 9 Box. 101 WATERFORD ROAD</u>			d. STREET ADDRESS <u>Rt. 9, Box. 101 WATERFORD ROAD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>BARBARA JOAN BURWICK</u>			4. DATE OF DEATH Month Day Year <u>NOVEMBER 10 1957</u>		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 23, 1940</u>		9. AGE (In years last birthday) <u>17</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>High School</u>		11. BIRTHPLACE (State or foreign country) <u>PENNINGTON GAP, VA.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>RAY BURWICK</u>			14. MOTHER'S MAIDEN NAME <u>CORDA WOODWARD</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>Mrs. Nell Wilson Same as no. #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the brain</u> <u>193X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>					INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>Pennington Gap, Va.</u>	(County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>R. M. McLaughlin</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>November 11, 1957</u>	
EXAMINER'S NAME (Type) <u>R. M. McLaughlin</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Nov. 13, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cecil Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Pennington Gap, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. V. Singleton</u>		ADDRESS <u>Shen Burnie, Md.</u>		24a. REC'D BY REGISTRAR <u>NOV 14 1957</u>	24b. REGISTRAR'S SIGNATURE <u>L. J. Adell</u>

RECEIVED
NOV 14 1957
BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. Prior to burial, cremation, or removal, DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11418

11426

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New York b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severna Park				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn 69X-3			
c. LENGTH OF STAY IN 1b 3 weeks				d. STREET ADDRESS 747 41st Street			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 115 Giddings Ave (Cape Arthur)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last MATTI CARLSON				4. DATE OF DEATH Month Day Year NOVEMBER 6 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 8, 1889	
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Carpenter				10b. KIND OF BUSINESS OR INDUSTRY General		11. BIRTHPLACE (State or foreign country) Finland	
13. FATHER'S NAME Paavo Carlson				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 051-09-2260		17. INFORMANT Address Mrs Anna Carlson - Wife - same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Heart Disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 year							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Natural causes			
20c. TIME OF INJURY Month, Day, Year Hour XX p. m. 11-6- 19 57		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Severna Park, A.A., Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Francis I. Codd				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Francis I Codd MD				DATE SIGNED 11-7-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 9, 1957		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Memorial Cemet.		22d. LOCATION (City, town, or county) (State) Annapolis, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home				ADDRESS Annapolis, Md.		24a. REC'D BY REGISTRAR NOV 12 1957	
				24b. REGISTRAR'S SIGNATURE L J. Codd			

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11419

11395

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A.A. Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A.A. Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>A.A. GENERAL Hospital</u>				e. STREET ADDRESS <u>2 Dogwood Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>EDWARD J. CARPENTER</u>				4. DATE OF DEATH Month Day Year <u>Nov. 24 1957</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-26-1910</u>	
9. AGE (In years last birthday) <u>47</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PRINTER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>TYPE SETTER</u>		11. BIRTHPLACE (State or foreign country) <u>MASS.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>THOMAS CARPENTER</u>				14. MOTHER'S MAIDEN NAME <u>MARY FITZGERALD</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>WW II</u>				16. SOCIAL SECURITY NO. <u>WV 111111</u>			
17. INFORMANT <u>MRS. JULIA CARPENTER</u>				Address <u>#2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary thrombosis</u> DUE TO <u>Coronary artery sclerosis, none</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>5 yrs.</u> DUE TO (b) <u>5 yrs.</u> DUE TO (c) <u>5 yrs.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH 7 minutes</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John L. Hedsman</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11/29/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>OAK GROVE</u>		22d. LOCATION (City, town, or county) (State) <u>Rock Port MASS.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Gortans</u>				24a. REC'D BY REGISTRAR <u>11/25/57</u>			
ADDRESS <u>Annapolis, Md.</u>				24b. REGISTRAR'S SIGNATURE <u>U. S. ...</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

NOV 27 1957

RECEIVED

11427 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bristol</u>		c. LENGTH OF STAY IN 1b <u>40 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deale Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Annie</u> Middle <u>Elizabeth</u> Last <u>CATTERTON</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>19</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 12, 1884</u>
9. AGE (In years last birthday) <u>73 yrs.</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Joseph Griffith</u>		14. MOTHER'S MAIDEN NAME <u>Mary Moreland</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>----</u>	
17. INFORMANT <u>Lillian M. Sherbert-</u>		Address <u>Bristol, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic CVR Disease</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>30 hrs.</u> <u>Unk</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July</u> , 19 <u>46</u> , to <u>Nov 19</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>19 Nov</u> , 19 <u>57</u> , and that death occurred at <u>8:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. B. Sasser</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>Upper Marlboro Md 19 Nov 57</u>	
PHYSICIAN'S NAME (Type) <u>R. B. Sasser, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/21/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Lothian, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ritchie Bros Funeral Home</u>		ADDRESS <u>Upper Marlboro, Md.</u>	
24a. REC'D BY REGISTRAR <u>NOV 25 57</u>		24b. REGISTRAR'S SIGNATURE <u>Quilley</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film G223 12-12-57 et

CERTIFICATE OF DEATH

11421

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Calvert County</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <i>Maryland</i> b. COUNTY <i>Calvert County</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Adelphi General Hospital</i>		d. STREET ADDRESS <i>106 South St.</i>	
3. NAME OF DECEASED (Type or print) First <i>Mary</i> Middle <i>Chambers</i> Last		4. DATE OF DEATH Month <i>11</i> Day <i>30</i> Year <i>1957</i>	
5. SEX <i>Female</i>		6. COLOR OR RACE <i>Colored</i>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <i>9-17-1904</i>	
9. AGE (In years last birthday) <i>53</i> yrs.		IF UNDER 1 YEAR: Months <i>53</i> Days <i>10</i> Hours <i>10</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired S. Navy code</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Skidmore Md.</i>	
11. BIRTHPLACE (State or foreign country) <i>U.S.A.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>William Chambers</i>		14. MOTHER'S MAIDEN NAME <i>Chene Harris</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>no</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	

PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <i>extensive inflammatory carcinoma left breast</i> DUE TO <i>breast</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Metastases to mediastinal, abd. lymphatics</i> DUE TO <i>extreme obesity</i> (c)		INTERVAL BETWEEN ONSET AND DEATH <i>10 months</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>lyonism & metastatic</i>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.	
20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <i>3-29</i> , 1947, to <i>11-29</i> , 1957, that I last saw the deceased alive on <i>11-28</i> , 1957, and that death occurred at <i>11:30 P.</i> M, from the causes and on the date stated above.	
ADDRESS (Street, city or town, state) <i>45 Franklin St. Annapolis Md.</i>		DATE SIGNED <i>12-3-57</i>	
ACTUAL SIGNATURE <i>Edith Rodler M.D.</i>		PHYSICIAN'S NAME (Type) <i>EDITH RODLER M.D.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12-4-57</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Brewer Hill</i>		22d. LOCATION (City, town, or county) (State) <i>Annapolis, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>William Reese, Jr. Annapolis, Md.</i>		24a. REC'D BY REGISTRAR <i>DEC 4 1957</i>	
ADDRESS <i>45 Franklin St. Annapolis Md.</i>		24b. REGISTRAR'S SIGNATURE <i>Am. French</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1515

BUREAU V. S.

1057 2 55

RECEIVED

TO SUPPLEMENT MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11422

Reg. Dist. No.

11397

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>410 Second St.</u>		2. USUAL RESIDENCE (Where deceased lived. If Institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u> d. STREET ADDRESS <u>1 410 Second St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Emmer</u> Middle <u>R.</u> Last <u>Chaney</u>		4. DATE OF DEATH Month <u>November</u> Day <u>10</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 8, 1871</u>
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (State or foreign country) <u>Annapolis, Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Robert W. Brown</u>	
14. MOTHER'S MAIDEN NAME <u>Isabella Puckett</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Daniel Chaney</u> Address <u>#2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac disease</u> DUE TO <u>434.3</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) <u>Sudden</u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u> </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u> </u> <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>[Signature]</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>F. Linhardt</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>11/17/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11-13-1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Bluff</u>	22d. LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor & Sons Annapolis, Md.</u>		24a. REC'D BY REGISTRAR <u> </u> 24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MEDICAL CERTIFICATION

RECEIVED

NOV 15 1957

BUREAU V. S.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

WEST AND STATE DEPARTMENT OF HEALTH - DIVISION 18

11428

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Essex</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Linthicum Heights</u>		c. LENGTH OF STAY IN 1b <u>5 weeks</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>209 - Poplar Ave.</u>		d. STREET ADDRESS <u>Adelina 04X2.2</u>	
3. NAME OF DECEASED (Type or print) <u>NANNIE-FLORINA-COCHRANE</u>		4. DATE OF DEATH <u>11/16/57</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/15/79</u>
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Robert County, Ind.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Mrs. Margaret Lesouse (daughter)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Intestinal Tract.</u> 153X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>7 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>		ADDRESS (Street, city or town, state) <u>Stevenson, Md.</u> DATE SIGNED <u>11/16/57</u>	
PHYSICIAN'S NAME (Type) <u>GUSTAVE-H. FAUBERT - M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11-19-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt Harmony</u>	22d. LOCATION (City, town, or county) (State) <u>Mt. Airy, Ind.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm H. Hutchins</u> ADDRESS <u>Wings Ind</u>		24a. REC'D BY REGISTRAR DATE <u>11/18/57</u>	24b. REGISTRAR'S SIGNATURE <u>G. H. Reduch</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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NOV 20 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11429

CERTIFICATE OF DEATH

Reg. Dist. No.

11429

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bar Harbor</u>		c. LENGTH OF STAY IN 1b <u>12 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>72 Johnson Rd.</u>		d. STREET ADDRESS <u>72 Johnson Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>ROSE</u> Middle <u>MARIE</u> Last <u>CROTHERS</u>		4. DATE OF DEATH Month <u>NOV.</u> Day <u>3</u> Year <u>19 57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/11/1886</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Henry Bessler</u>		14. MOTHER'S MAIDEN NAME <u>Katherine Young</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>	
17. INFORMANT <u>Mr William B. Crothers</u>		Address <u>72 Johnson Rd. Bar Harbor</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X</u> DUE TO <u>Hypertensive Cardio-Vascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>2 years</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>OCT 1, 1957</u> to <u>NOV. 3, 1957</u> , that I last saw the deceased alive on <u>Nov. 1, 1957</u> , and that death occurred at <u>5:20 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. Brady Smith</u>		ADDRESS (Street, city or town, state) <u>RIVIERA BEACH, MD</u>	
PHYSICIAN'S NAME (Type) <u>J. BRADY SMITH</u>		DATE SIGNED <u>11/3/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/6/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>London Park Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>3801 Frederick Ave</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. G. Kelly</u>		ADDRESS <u>110 V 5 1957</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8, Film G222, 11/22/57 fcy

CERTIFICATE OF DEATH

11425

Reg. Dist. No. 21

11398

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>111 Granada Ave.</u>		d. STREET ADDRESS <u>111 Granada Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>HARRY</u> Middle <u>W</u> Last <u>DADDS</u>		4. DATE OF DEATH Month <u>NOVEMBER</u> Day <u>13</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1889</u> <u>April 15, 1957</u>
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Plaster</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home Constructions</u>	
11. BIRTHPLACE (State or foreign country) <u>Annapolis, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Dadds</u>		14. MOTHER'S MAIDEN NAME <u>Christania Harold</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>212-16-6740</u>	
17. INFORMANT <u>Mrs Pearl Dadds- Wife- same as # 2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardio Vascular Disease</u> DUE TO (c) <u>1 day</u> <u>1 1/2</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 1, 1956</u> , to <u>Nov 13, 1957</u> , that I last saw the deceased alive on <u>11-13-57</u> , and that death occurred at <u>12:30</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>3 Shaw Street Annapolis, Md</u> DATE SIGNED <u>11/14/57</u>			
ACTUAL SIGNATURE <u>James R. Martin</u> M.D.		PHYSICIAN'S NAME (Type) <u>James R. Martin MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-16-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Bluff Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOPPING FUNERAL HOME</u>		ADDRESS <u>Annapolis, Md.</u>	
24a. REC'D BY REGISTRAR <u>NOV 18 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mr. J. J. ...</u>	

BUREAU V. S.

NOV 18 1957

RECEIVED

11399 CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN IB 1 day	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lake Shore (Pasadena)		d. STREET ADDRESS Rt 7 Box 402, Pasadena, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ZEALON Middle BENJAMIN Last DAVENPORT		4. DATE OF DEATH Month November Day 9 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 28, 1898
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Typewriter operator		10b. KIND OF BUSINESS OR INDUSTRY Commercial Printing	
11. BIRTHPLACE (State or foreign country) N.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 139-05-6299	
17. INFORMANT Mrs Mary A. Davenport- Wife- same as # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema DUE TO (b) Cardiac decompensation DUE TO (c) Cardiac hypertrophy Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 24 hours 3 weeks unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 23, 1957 , to Nov. 9, 1957 , that I last saw the deceased alive on Nov. 9, 1957 , and that death occurred at 9:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Arthur Lankford Jr.		ADDRESS (Street, city or town, state) DATE SIGNED Mountain Rd. Pasadena Md.	
PHYSICIAN'S NAME (Type) Arthur Lankford Jr., MD		Mt. Road, Pasadena, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF 11-11-57	22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Crematory	22d. LOCATION (City, town, or county) (State) Prince George's County, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home		24a. REC'D BY REGISTRAR NOV 12 1957	
ADDRESS Annapolis, Maryland		24b. REGISTRAR'S SIGNATURE French	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

BUREAU V. 3

NOV 12 1957

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11427

11430

Items 11, 12, 13, 14 Film G223 11-29-57 et

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>A.A.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAUREL</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>First Aid - ROOM</u>		d. STREET ADDRESS <u>3152 Stanton Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>JOHN H. DEADWYLER</u>		4. DATE OF DEATH <u>Nov. 11 - 1957</u> 19	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>C.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/20/09</u>
9. AGE (In years last birthday) <u>48</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Commerce, Georgia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Deadwyler</u>		14. MOTHER'S MAIDEN NAME <u>Georgianna Deadwyler</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gustave H. Faubert</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>GUSTAVE H. FAUBERT M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>11/11/57</u>	
22a. BURIAL CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>11/16/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Lincoln</u>	22d. LOCATION (City, town, or county) (State) <u>Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert G. Mason</u>		24a. REC'D BY REGISTRAR <u>Nov 18 '57</u>	24b. REGISTRAR'S SIGNATURE <u>Quel...</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

NOV 18 1957

BUREAU V. S.

STATE
HEALTH DEPT.

STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

114288

11431 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville, Md.		c. LENGTH OF STAY IN 1b 3 mo., 21da.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital, Md.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3001-4	
3. NAME OF DECEASED (Type or print) First William Middle C. Last DeJonso		4. DATE OF DEATH Month 11 Day 14 Year 19 57	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/12/10
9. AGE (In years last birthday) 47 yrs.		10. FINDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Columbus DeJonso		14. MOTHER'S MAIDEN NAME Gertrude Washington	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 214-18-5484	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal Bronchopneumonia DUE TO Aspiration Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Aneurysm. Post-operative Hemiplegia			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 24 , 19 57 , to November 14 , 19 57 , that I last saw the deceased alive on November 14 , 19 57 , and that death occurred at 7:55AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 11/15/57			
ACTUAL SIGNATURE Ludwig Benedict		M.D. Crownsville, Md.	
PHYSICIAN'S NAME (Type) Ludwig Benedict, M. D.		Crownsville State Hospital, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11-18-57	
22c. NAME OF CEMETERY OR CREMATORY BALTO. NAT'L CEMETERY		22d. LOCATION (City, town, or county) (State) BALTO. MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Charles R. Lane		ADDRESS 802 Madison Ave	
24a. REC'D BY REGISTRAR NOV 19 1957		24b. REGISTRAR'S SIGNATURE M. Joyce	

RECEIVED

NOV 19 1957

BUREAU V. S.

CERTIFICATE OF DEATH

11432

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beechwood Forest</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beechwood Forest</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rt. 5, Box 115 Pasadena Md</u>		d. STREET ADDRESS <u>Rt. 5, Box 115 Pasadena</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>M.</u> Middle <u>Helen</u> Last <u>DeLaney</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>24</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/9/1968</u>
9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR: Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Ireland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT Address <u>Rt 5, Box 115 Pasadena Md</u>		Name <u>Mrs Frances Marion Barnes</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the breast</u> 170x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive, arteriosclerotic cardio-vascular disease</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u> <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>none</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>November 1, 1953</u> to <u>November 24, 1957</u> , that I last saw the deceased alive on <u>November 23, 1957</u> , and that death occurred at <u>4:15 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. M. McLaughlin</u>		ADDRESS (Street, city or town, state) <u>Mountain Road Pasadena, Md.</u>	
PHYSICIAN'S NAME (Type) <u>R. M. McLaughlin</u>		DATE SIGNED <u>Nov 24, 1957</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/27/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cmn</u>	22d. LOCATION (City, town, or county) (State) <u>4300 Old Frederick Rd.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Cowan</u>		ADDRESS <u>43 Collins St.</u>	
24a. REC'D BY REGISTRAR <u>NOV 27 1957</u>		24b. REGISTRAR'S SIGNATURE <u>L J. Kelly</u>	

BURKAW V. S.

NOV 27 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 6. See: Birth Cert. et

CERTIFICATE OF DEATH

11430

Reg. Dist. No. 27

11433

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ft Meade, Md		c. LENGTH OF STAY IN 1b 1 da 14½ hrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Army Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
3. NAME OF DECEASED (Type or print) First MORRIS Middle FRANK Last DOZIER		4. DATE OF DEATH Month November Day 17 Year 19 57	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 15 Nov 57
9. AGE (In years last birthday) yrs. 1		10. IF UNDER 1 YEAR Months 1 Days 14½ Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank MMI Dozier		14. MOTHER'S MAIDEN NAME Helga G Wolf	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. None	
17. INFORMANT Father, 1240 N. Curley St, Baltimore, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral damage due to septicemia and meningitis 768.0 DUE TO meningitis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 21c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 21d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 21e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 21f. (City or town) (County) (State)		INTERVAL BETWEEN ONSET AND DEATH 1 day 14½ hrs	
21. I certify that I attended the deceased from 16 Nov 57 , to 17 Nov 57 , that I last saw the deceased alive on 17 Nov 57 , and that death occurred at 0255 A.M. , from the causes and on the date stated above.		DATE SIGNED	
ACTUAL SIGNATURE John L. Robertson Capt MC M.D. U.S.A.H. Ft Meade Md.		ADDRESS (Street, city or town, state)	
PHYSICIAN'S NAME (Type) JOHN L. ROBERTSON, Capt, MC			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-20-57	22c. NAME OF CEMETERY OR CREMATORY Baltimore National	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE Earl M. Roberts, Funeral Home Inc 6306 Belair Rd. Balt. - 6		24a. REC'D BY REGISTRAR DATE 18 Nov 57	
24b. REGISTRAR'S SIGNATURE Wilbur H. Downs, Jr. Capt. MSC			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

RECEIVED
 NOV 21 1957
 BUREAU V. S.

DATE OF DEATH		PLACE OF DEATH	
TIME OF DEATH		CITY	
AGE		SEX	
RACE		EDUCATION	
OCCUPATION		MARRIAGE	
CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE OF REGISTRATION		PLACE OF REGISTRATION	
FILING OFFICE		FILING NUMBER	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11431

11400

CERTIFICATE OF DEATH

Reg. Dist. No.

21

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel Gen'l Hospital</u>				d. STREET ADDRESS <u>Crain High Way</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Roger</u> Middle <u>Howard</u> Last <u>Drury</u>				4. DATE OF DEATH Month <u>November</u> Day <u>15</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 18, 1890</u>	
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months <u>67</u> Days <u>67</u> Hours <u>67</u> Min. <u>67</u>		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic (ret.)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>W.B.&A. R.R.Co.</u>		11. BIRTHPLACE (State or foreign country) <u>St. Mary's Co., Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John W. Drury</u>				14. MOTHER'S MAIDEN NAME <u>Mary V. Russell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mr. Roger H. Drury</u> Address <u>Gambrills, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>260x</u> DUE TO <u>with congestive failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Thrombotic embolism with trigeminal nerve</u> (c) <u>with trigeminal nerve</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1</u> INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>10-15-57</u> 19, to <u>11-15-57</u> 19, that I last saw the deceased alive on <u>10-15-57</u> 19, and that death occurred at <u>M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A. T. Allen</u> M.D. <u>62 Rockwell St</u> DATE SIGNED <u>11-15-57</u>							
PHYSICIAN'S NAME (Type) <u>A T ALLEN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 19, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Our Lady of the Field</u>		22d. LOCATION (City, town, or county) (State) <u>Millersville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Richard K. Sargent</u> ADDRESS <u>Glen Burnie, Md.</u>				24a. REC'D BY REGISTRAR <u>Nov 20 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Thm J. French</u>	

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The body copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11432

11434

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ANNE ARUNDEL		MARYLAND		STATE MARYLAND		COUNTY ANNE ARUNDEL	
CITY (If outside corporate limits, write RURAL and give nearest town) GLEN BURNIE		LENGTH OF STAY (in this place) 11 yrs.		CITY (If outside corporate limits, write RURAL and give nearest town) GLEN BURNIE			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 6720 Gov. Ritchie Hwy.				STREET ADDRESS (If rural give location) 6720 Gov. Ritchie Hwy.			
3. NAME OF DECEASED (Type or Print) GABRIEL (First) ENSENAT (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year) Nov. 2 1957			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH May, 29, 1892	9. AGE last birthday 65 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Restaurenter		10b. KIND OF BUSINESS OR INDUSTRY Self Employed		11. BIRTHPLACE (State or foreign country) Spain		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Pete Ensenat				14. MOTHER'S MAIDEN NAME Medeline (Unknow)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. 220-22-3847		17. INFORMANT & ADDRESS Mr. Pete Ensenat, Same as No. #2			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
156.1 IMMEDIATE CAUSE (A) Carcinoma of Linc & Metastatic						26 July 57	
ANTECEDENT CAUSE(S) DUE TO						+0	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO						2 Nov 57	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION 9/30/57		19b. MAJOR FINDINGS OF OPERATION Carcinoma of Linc & Metastatic				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 26 July 1957, to 28 Oct 1957, that I last saw the deceased alive on 28 Oct 1957, and that death occurred at 2:15 P.M. from the causes and on the date stated above.							
SIGNATURE [Signature]				DATE SIGNED 4016 Ritchie Hwy Baltimore Nov 57			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Nov. 6, 57		NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery		LOCATION (City, town, or county) (State) Glen Burnie, Maryland	
24. REC'D BY REGISTRAR NOV 6 1957		REGISTRAR'S SIGNATURE [Signature]		25. FUNERAL DIRECTOR'S SIGNATURE [Signature]		ADDRESS Glen Burnie, Md.	

CERTIFICATE OF DEATH

DATE OF DEATH

A. QUALIFYING OFFICER OF DEATH

FAMILY AND

PERSONAL DATA

DEATH

CAUSE

PLACE

TIME

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

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BUREAU V. J.

NOV 6 1957

RECEIVED

11435 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY A.A. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY A.A.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 50 Brooklyn	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 207 Cresswell Road		d. STREET ADDRESS 207 Cresswell Road	
3. NAME OF DECEASED (Type or print) First JOSEPH A. Middle FELBINGER Last		4. DATE OF DEATH II/7/57 Day 19 Year	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/21/87
9. AGE (In years last birthday) yrs. 70		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shoemaker		10b. KIND OF BUSINESS OR INDUSTRY Dixie-Bartlett	
11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Andrew		14. MOTHER'S MAIDEN NAME Anna ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Family - Same		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 163x Carcinoma, Melanotic DUE TO Carcinoma Lung Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 6 mo 1 year
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 16, 1956 , to July 7, 1957 , that I last saw the deceased alive on July 7, 1957 , and that death occurred at 3 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Benjamin Berdann M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 5010 A Ritchie Hwy Baltimore Nov 25 1957	
PHYSICIAN'S NAME (Type) BENJAMIN BERDANN			
22a. BURIAL, CREMATION, REMOVAL (Specify) B	22b. DATE THEREOF II/II/57	22c. NAME OF CEMETERY OR CREMATORY St. Mathews	22d. LOCATION (City, town, or county) (State) Baltimore
23. FUNERAL DIRECTOR'S SIGNATURE McCully Funeral Homes - 130 E. Fort Avenue		24a. REC'D BY REGISTRAR NOV 12 1957	
		24b. REGISTRAR'S SIGNATURE Eda Shuteau	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11436

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11434

Items 8, 9 Film G222 11-13-27 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Georgetown near Jessup, MD</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Georgetown near Jessup</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <u>BENJAMIN</u> First <u>GAITHER</u> Middle <u>GAITHER</u> Last				4. DATE OF DEATH <u>Nov</u> Month <u>2nd</u> Day <u>19</u> Year <u>87</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar 12 1892</u>	9. AGE (In years last birthday) <u>64</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B & O Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Walter Gaither</u>				14. MOTHER'S MAIDEN NAME <u>Mary Williams</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>414187B</u>		17. INFORMANT <u>Nora Gaither</u> Address <u>Jessup R. F. D.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis -</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Influenza.</u> <u>481X</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>1 hr.</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank E. Shipley, M.D.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Frank E. Shipley</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>Nov-5-1987</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Rest</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ridgely Selby</u>				ADDRESS <u>401 West ...</u>		24a. REC'D BY REGISTRAR <u>Clara Haslup</u>	
				DATE <u>Nov 5 1987</u>		24b. REGISTRAR'S SIGNATURE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Item 18. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

NOV 5 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11435 28

11437

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville, Md.		c. LENGTH OF STAY IN 1b 5ys, 4mo, 16da.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		3yos 14	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital, Md.		d. STREET ADDRESS 511 N. Arlington Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ernest Middle Bernard Last Gaskins		4. DATE OF DEATH Month 11 Day 19 Year 1957	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/2/1912
9. AGE (In years last birthday) 45 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Porter		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown ALFRED		14. MOTHER'S MAIDEN NAME Hattie Woods	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Insufficiency DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diffuse Myocardial DUE TO (c) Fibrosis - Coronary Sclerosis		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Schizophrenic Reaction - Catatonic Type			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 12/30 19 51		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/30 , 19 51 , to 11/19 , 19 57 , that I last saw the deceased alive on November 19 , 19 57 , and that death occurred at 5:30 A. M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 11/19/57	
ACTUAL SIGNATURE Ludwig Benedict		M.D. Crownsville State Hospital, Md.	
PHYSICIAN'S NAME (Type) Ludwig Benedict, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-22-57	
22c. NAME OF CEMETERY OR CREMATORY Mt. Calvary		22d. LOCATION (City, town, or county) (State) a. a. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Samuel W. Sullivan Jr - Balt		ADDRESS Baltimore	
24a. REC'D BY REGISTRAR NOV 21 1957		24b. REGISTRAR'S SIGNATURE H. M. Joyce	

BUREAU V. S.

NOV 13 1951

RECEIVED

11438

CERTIFICATE OF DEATH

Reg. Dist. No.

25

1. PLACE OF DEATH o. COUNTY A.A. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY A.A.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn		c. LENGTH OF STAY IN 1b 50	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 202 Arden Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First SOPHIA Middle GATES Last		4. DATE OF DEATH Month II Day 11 Year 57	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/2/96
9. AGE (In years last birthday) yrs. 61		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Leopold Krimmelbein		14. MOTHER'S MAIDEN NAME Theodora Schultz	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Family - Same		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adeno-carcinoma of ovaries DUE TO (b) Metastatic carcinoma of lungs DUE TO (c) 175x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH about 5 yrs. 1 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension & arteriosclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 19 55 , to Nov. 19 57 , that I last saw the deceased alive on Nov. 19 57 , and that death occurred at 3 p.m. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 1802 Eastern Ave	
ACTUAL SIGNATURE John V. Szerbiak M.D.		DATE SIGNED	
PHYSICIAN'S NAME (Type) John V. Szerbiak			
22a. BURIAL, CREMATION, REMOVAL (Specify) B		22b. DATE THEREOF II/14/57	
22c. NAME OF CEMETERY OR CREMATORY Meadowridge		22d. LOCATION (City, town, or county) (State) Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE McCully Funeral Homes - 130 E. Fort Avenue		24a. REC'D BY REGISTRAR NOV 14 1957	
		24b. REGISTRAR'S SIGNATURE Tha. Hutson	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 14 1957

RECEIVED

11401

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HUNNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>A.A. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOHIS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 ANNAPOHIS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HUNNE ARUNDEL GENERAL HOSP</u>		d. STREET ADDRESS <u>4 RANDALL PLACE</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>GEORGE LEWIS HARDESTY</u>		4. DATE OF DEATH Month Day Year <u>11 4 1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/19/1877</u>
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>POSTMASTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CIVIL SERVICE</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>WILLIAM ESTED HARDESTY</u>		14. MOTHER'S MAIDEN NAME <u>MARTHA ELLEN CHANEY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>MAEL HARDESTY</u> Address <u>#2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>generalized arteriosclerosis</u> DUE TO (c) <u>Parkinson's disease, dementia</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April</u> , 19 <u>57</u> , to <u>Nov 4</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Nov 4</u> , 19 <u>57</u> , and that death occurred at <u>4:05 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wm H. Wilson</u>		ADDRESS (Street, city or town, state) <u>Artisan, Md</u>	
PHYSICIAN'S NAME (Type) <u>—</u>		DATE SIGNED <u>11-6-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11/6/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ST. JAMES</u>		22d. LOCATION (City, town, or county) (State) <u>TRACEY'S MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor & Sons</u>		ADDRESS <u>Annapolis, Md.</u>	
24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>	
DATE <u>11/7/57</u>			

1. PLACE OF DEATH a. COUNTY <u>A. A. County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A. A. County</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brownwood</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Brownwood</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A. A. General Hospital</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Lera</u> Middle <u>Harold</u> Last		4. DATE OF DEATH Month <u>11</u> Day <u>16</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-13-1892</u>
9. AGE (In years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR: Months <u>6</u> Days <u>16</u> Hours <u>57</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Clasiah Stansbury</u>		14. MOTHER'S MAIDEN NAME <u>Gemmie Chambers</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Charles Harold - Anna, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-vascular accident</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>11-15-57</u> , 19 <u>57</u> , to <u>11-16-57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11-16-57</u> , 19 <u>57</u> , and that death occurred at <u>6:15</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>G. T. Allen</u> M.D.		ADDRESS (Street, city or town, state) <u>62 E. Cathedral St</u> DATE SIGNED <u>11-17-57</u>	
PHYSICIAN'S NAME (Type) <u>A. T. ALLEN</u>		<u>Ann Arbor, Mich</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11-20-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Broad Neck</u>	22d. LOCATION (City, town, or county) (State) <u>Skidmore, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese #108 Wash. St. Baltimore</u>		24a. REC'D BY REGISTRAR <u>11/19/57</u>	24b. REGISTRAR'S SIGNATURE <u>Wm. J. French</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES H. WOODWARD		2. SEX Male	
3. AGE 65		4. RACE White	
5. DATE OF DEATH Nov 20 1957		6. PLACE OF DEATH Home	
7. CITY OF RESIDENCE Baltimore		8. COUNTY OF RESIDENCE Baltimore	
9. STATE OF RESIDENCE Maryland		10. MARITAL STATUS Married	
11. OCCUPATION Retired		12. CAUSE OF DEATH Heart Disease	
13. MEDICAL HISTORY Hypertension, Atherosclerosis		14. PRESENT ILLNESS Myocardial Infarction	
15. PHYSICIAN'S SIGNATURE [Signature]		16. MEDICAL EXAMINER'S SIGNATURE [Signature]	
17. DATE OF SIGNATURE Nov 20 1957		18. PLACE OF SIGNATURE Baltimore	

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NOV 20 1957
BUREAU V. 2

11439

CERTIFICATE OF DEATH

Reg. Dist. No.

11440

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Odenton Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Odenton Maryland</u> x2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Frank S. Harrison</u>		4. DATE OF DEATH Month <u>11</u> Day <u>24</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-1-1895</u>
9. AGE (In years last birthday) <u>62</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Janitor</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Odenton Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Richard Harrison</u>		14. MOTHER'S MAIDEN NAME <u>Josephine White</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-03665</u>	
17. INFORMANT <u>Margaret Harrison</u>		Address <u>Odenton Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary - vascular accident</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>11-22-57</u> , 19 <u>57</u> , to <u>11-24-57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11-24-57</u> , 19 <u>57</u> , and that death occurred at <u>7:45</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. T. Allen</u>		DATE SIGNED <u>11-26-57</u>	
PHYSICIAN'S NAME (Type) <u>A T ALLEN</u>		ADDRESS (Street, city or town, state) <u>Annapolis Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11-28-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Faulkner</u>	22d. LOCATION (City, town, or county) (State) <u>Odenton, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr. Annapolis, Md.</u>		24a. REC'D BY REGISTRAR <u>11/26/57</u>	24b. REGISTRAR'S SIGNATURE <u>Charles Phelps</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 27 1957

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The body copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled out by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11441

CERTIFICATE OF DEATH

Reg. Dist. No. 24

11440

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Anne Arundel</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Ferndale</u>		LENGTH OF STAY (in this place) <u>27 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Ferndale, Glen Burnie P.O.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>#104 Hollins Ferry Road</u>				STREET ADDRESS <u>#104 Hollins Ferry Road</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Mary</u> (Middle) <u>Frances</u> (Last) <u>Hartley</u>				(Month) <u>Nov.</u> (Day) <u>13</u> (Year) <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Nov. 2, 1877</u>	9. AGE last birthday <u>80</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Fairfax Co., Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George T. Hughes</u>				14. MOTHER'S MAIDEN NAME <u>Florence Brown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>303 Orchard Rd. Mr. Carroll Cook Ferndale, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						4 days	
420.1 IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1951</u> , 19 <u> </u> , to <u>Nov. 13, 1957</u> , that I last saw the deceased alive on <u>Nov. 11, 1957</u> , and that death occurred at <u>10:00 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>C. Milton Litcher</u>				ADDRESS (Street, city, town, state) <u>Linthicum Heights, Md.</u>			
DATE SIGNED <u>Nov. 14/57</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Nov. 16/57</u>		NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem.</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
24. REC'D BY REGISTRAR <u>NOV 18 1957</u>		REGISTRAR'S SIGNATURE <u>L. J. Seelbach</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>R. S. Singleton</u>		ADDRESS <u>Glen Burnie, Md.</u>	

CERTIFICATE OF DEATH

Form 10-1-18

TO BE FILLED BY THE PHYSICIAN OR OTHER PERSON HAVING KNOWLEDGE OF THE CAUSE OF DEATH

1. Name of Deceased		2. Sex		3. Age		4. Race		5. Date of Birth		6. Date of Death		7. Place of Birth		8. Usual Residence		9. Cause of Death		10. Manner of Death		11. Signature of Physician		12. Signature of Registrar	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 11442

11441 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 57

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Anne Arundel</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings</u>		c. LENGTH OF STAY IN 1b <u>1</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First <u>EVERETT</u> Middle <u>HAWKINS</u> Last <u>HAWKINS</u>			4. DATE OF DEATH Month <u>11</u> Day <u>29</u> Year <u>57</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct-21</u>	9. AGE (in years last birthday) <u>14</u> yrs.	IF UNDER 1 YEAR Months <u>11</u> Days <u>29</u> Hours <u>19</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>md</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>			13. FATHER'S NAME <u>Fred Hawkins</u>		
14. MOTHER'S MAIDEN NAME <u>Helen Mackall</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.			17. INFORMANT <u>Helen Hawkins Owings, md</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Traumatic Injuries</u> <u>813X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto-bike collision</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>11</u> o. m. <u>19</u> 19 <u>57</u> p. m.		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>street</u>	
20f. (City or town) <u>Owings</u>		20g. (County) <u>Anne Arundel</u>		20h. (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> <u>Partial</u>					
ACTUAL SIGNATURE <u>William V. Lovitt</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>11/20/57</u>	
EXAMINER'S NAME (Type) <u>William V. Lovitt, Jr., M.D.</u>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. (BURIAL) CREMATION, REMOVAL (Specify) <u>Nov-24-57</u>		22b. DATE THEREOF <u>Nov-24-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Moses</u>	
22d. LOCATION (City, town, or county) <u>AA</u>		22e. (State) <u>md</u>		22f. REGISTRAR'S SIGNATURE <u>H. W. Ward</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>P. E. Sewell Prince Frederick, Md.</u>		ADDRESS <u>11-25-57</u>		24a. REC'D BY REGISTRAR DATE <u>11-25-57</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

NAME OF DECEASED

DATE OF DEATH

SEX

AGE

CAUSE OF DEATH

PLACE OF DEATH

DATE OF EXAMINATION

BUREAU V. S.

NOV 27 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registry prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11443

11442

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD. b. COUNTY AACo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DEALE, MD.				c. LENGTH OF STAY IN 1b LIFE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION NONE				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ANNIE FRANCES (NANNIE) First Middle Last				4. DATE OF DEATH NOV. 2 1957 Month Day Year			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/17/88	
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? USA.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME John Wm Phipps				14. MOTHER'S MAIDEN NAME Rispha Phipps			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO. (If yes, give war or dates of service)				17. INFORMANT ELLA PHIPPS, Address DEALE, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 170x GENERALIZED CARCINOMATOSIS. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARCINOMA OF BREAST DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from 9/24 , 19 57 , to 11/2 , 19 57 , that I last saw the deceased alive on 10/30 , 19 57 , and that death occurred at 7:30 A .M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 68 Franklin St DATE SIGNED 11/2/57.			
ACTUAL SIGNATURE Richard N. Peeler M.D.				PHYSICIAN'S NAME (Type) RICHARD N. PEELER, Annapolis, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/5/57		22c. NAME OF CEMETERY OR CREMATORY St James		22d. LOCATION (City, town, or county) (State) Tracy Sharnock Md	
23. FUNERAL DIRECTOR'S SIGNATURE Bernard Hardisty ADDRESS Galesville Md				24a. REC'D BY REGISTRAR NOV 6 1957 24b. REGISTRAR'S SIGNATURE V. Ormick			

CERTIFICATE OF DEATH

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]	
3. AGE [Faint text]		4. RACE [Faint text]	
5. DATE OF BIRTH [Faint text]		6. PLACE OF BIRTH [Faint text]	
7. DATE OF DEATH [Faint text]		8. PLACE OF DEATH [Faint text]	
9. CAUSE OF DEATH [Faint text]		10. MANNER OF DEATH [Faint text]	
11. SIGNATURE OF PHYSICIAN [Faint text]		12. SIGNATURE OF REGISTRAR [Faint text]	
13. SIGNATURE OF WITNESS [Faint text]		14. SIGNATURE OF WITNESS [Faint text]	
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99. SIGNATURE OF WITNESS [Faint text]		100. SIGNATURE OF WITNESS [Faint text]	

BUREAU V. S.

NOV 8 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11444

Reg. Dist. No.

11443

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville, Md.		c. LENGTH OF STAY IN 1b 13ys, 1mo, 22da	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wayside, Md. 08X0.2		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Loretta Middle Hill Last Hill		4. DATE OF DEATH Month 11 Day 9 Year 19 57	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unknown
9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR Months 66 Days 66 Hours 66 Min.	IF UNDER 24 HRS. Months 66 Days 66 Hours 66 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Congestion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pneumonia Pleural Effusion DUE TO (c) Convulsive Disorder			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Convulsive Disorder			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Unknown	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 11 p. m. 45		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Unknown		20f. (City or town) (County) (State) Unknown	
21. I certify that I attended the deceased from September 18 1944 , to November 9 19 57 , that I last saw the deceased alive on November 9 19 57 , and that death occurred at 11:45^a M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 11/12/57 ACTUAL SIGNATURE Lionel McHenry Mapp PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D. Crownsville State Hospital, Md.			
22a. BURIAL CREMATION/REMOVAL (Specify) Burial		22b. DATE THEREOF 11/14/57	
22c. NAME OF CEMETERY OR CREMATORY Walden Med School		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE William K. Foster		24. REC'D BY REGISTRAR 11/18/57	
ADDRESS 108 W. 1st St. Crownsville, Md.		24b. REGISTRAR'S SIGNATURE J. M. Joyce	

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 65	
4. DATE OF DEATH Nov 19 1957		5. TIME OF DEATH 10:00 AM		6. PLACE OF DEATH Home	
7. CAUSE OF DEATH Heart Disease		8. MANNER OF DEATH Natural		9. PLACE OF BIRTH Maryland	
10. DATE OF BIRTH Nov 19 1957		11. TIME OF BIRTH 10:00 AM		12. PLACE OF BIRTH Maryland	
13. NAME OF PHYSICIAN J. H. Harris		14. NAME OF HOSPITAL None		15. NAME OF NURSE None	
16. NAME OF FUNERAL HOME None		17. NAME OF BURIAL PLACE None		18. NAME OF CEMETERY None	
19. NAME OF INTERVIEWER None		20. NAME OF WITNESS None		21. NAME OF SIGNER None	
22. NAME OF SIGNER None		23. NAME OF SIGNER None		24. NAME OF SIGNER None	
25. NAME OF SIGNER None		26. NAME OF SIGNER None		27. NAME OF SIGNER None	
28. NAME OF SIGNER None		29. NAME OF SIGNER None		30. NAME OF SIGNER None	
31. NAME OF SIGNER None		32. NAME OF SIGNER None		33. NAME OF SIGNER None	
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100. NAME OF SIGNER None		101. NAME OF SIGNER None		102. NAME OF SIGNER None	

BUREAU V. S.

NOV 19 1957

RECEIVED

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11445

11403

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>10</u> <u>Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9 Martin Street</u>				d. STREET ADDRESS <u>9 Martin Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JULIA</u> Middle <u>ELIZABETH</u> Last <u>HOBAN</u>				4. DATE OF DEATH Month <u>NOVEMBER</u> Day <u>18</u> Year <u>19 57</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 27, 1878</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>never worked</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>never worked</u>		11. BIRTHPLACE (State or foreign country) <u>Annapolis, Maryland</u>	
13. FATHER'S NAME <u>Patrick Hoban</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mr. Charles Hoban - Nephew - same as # 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of finger</u> <u>199.9</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of finger</u> DUE TO (c) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>2 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Annapolis</u>				20g. (County) <u>Anne Arundel</u>		20h. (State) <u>Md.</u>	
21. I certify that I attended the deceased from <u>7-10-</u> , 19 <u>54</u> , to <u>11-18-</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11-18-</u> , 19 <u>57</u> , and that death occurred at <u>6:30</u> A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>6 Shaw Street, Annapolis, Md.</u> DATE SIGNED <u> </u>							
ACTUAL SIGNATURE <u>James R. Martin</u> M.D.							
PHYSICIAN'S NAME (Type) <u>James R. Martin MD</u>				6 Shaw Street, Annapolis, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-21-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u>				ADDRESS <u>Annapolis, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 29 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Dr. French</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11446

11404

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>a a</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>md</i> b. COUNTY <i>a a</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>a. a. General</i>		d. STREET ADDRESS <i>1</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Jessie</i> Middle <i>May</i> Last <i>Hopkins</i>		4. DATE OF DEATH Month <i>11</i> Day <i>22</i> Year <i>1957</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6/10/78</i>
9. AGE (In years last birthday) <i>79</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homemaker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Cumbersome Ltd</i>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Robert Smith Hunt</i>		14. MOTHER'S MAIDEN NAME <i>Rebecca F. Peake</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mrs Louise Woodfield Salisbury Ltd</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronchopneumonia</i> DUE TO (b) <i>Generalized infection, site</i> DUE TO (c) <i>undetermined</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2-3 days</i> <i>4 mos.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>491X</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1950</i> , 19____, to <i>11-22-1957</i> , that I last saw the deceased alive on <i>11-22-57</i> , 19____, and that death occurred at <i>10 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Frank M. Shipley</i>		ADDRESS (Street, city or town, state) DATE SIGNED <i>11.23.57</i>	
PHYSICIAN'S NAME (Type) <i>Frank M. Shipley</i>		<i>Annapolis, md</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>11/24/57</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Leahey</i>	22d. LOCATION (City, town, & county) (State) <i>Salisbury Ltd</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Miss M. Hardaway</i>		24a. REC'D BY REGISTRAR DATE <i>DEC 2 1957</i>	
ADDRESS <i>Salisbury Ltd</i>		24b. REGISTRAR'S SIGNATURE <i>M. J. French</i>	

BUREAU V. S.

DEC 2 1957

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The body copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11447

CERTIFICATE OF DEATH

Reg. Dist. No. 24

11444

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ANNE ARUNDEL		MARYLAND		STATE MARYLAND		COUNTY ANNE ARUNDEL	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN GREEN HAVEN		LENGTH OF STAY (in this place) 10 YEARS		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN GREEN HAVEN			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 10 TH STREET				STREET ADDRESS (If rural give location) 1 10 TH STREET			
3. NAME OF DECEASED (Type or Print) (First) LURA (Middle) BESTA (Last) HORSEMAN				4. DATE OF DEATH (Month) (Day) (Year) NOV. 30 19 57			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH AUG. 15, 1891	9. AGE last birthday 66 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) CAMBRIDGE MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JAMES M. HIGGINS				14. MOTHER'S MAIDEN NAME DELLA LARRIMORE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) NO		16. SOCIAL SECURITY NO. 217-03-0836		17. INFORMANT & ADDRESS JAMES G. HORSEMAN - SAME			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
156.1 IMMEDIATE CAUSE (A) CARCINOMA LIVER						2 YEARS	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE 2 YEARS	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from MAY 19 56, to NOV. 30, 19 57, that I last saw the deceased alive on NOV. 29, 19 57, and that death occurred at 5:30 P.M. from the causes and on the date stated above.							
SIGNATURE J. Brady Smith				ADDRESS (Street, city, town, state) RIVIERA BEACH MD.		DATE SIGNED 11/30/57	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF 12-4-57		NAME OF CEMETERY OR CREMATORY GREEN HAVEN		LOCATION (City, town, or county) Baltimore	
24. REC'D BY REGISTRAR DATE DEC 2 1957		REGISTRAR'S SIGNATURE L. J. Seelbach		25. FUNERAL DIRECTOR'S SIGNATURE McCauley		ADDRESS Fleming House	

CERTIFICATE OF DEATH

Mass. Dept. H.

1. USUAL RESIDENCE (MAY BE CHANGED)

2. PLACE OF DEATH

3. MARRIAGE

4. DECEASED

5. DATE

6. TIME

7. PLACE

8. CAUSE

9. MANNER

10. SEX

11. AGE

12. RACE

13. BIRTH

14. DEATH

15. PLACE

16. CAUSE

17. MANNER

18. SEX

19. AGE

20. RACE

21. BIRTH

22. DEATH

23. PLACE

24. CAUSE

25. MANNER

26. SEX

27. AGE

28. RACE

29. BIRTH

30. DEATH

31. PLACE

32. CAUSE

33. MANNER

34. SEX

35. AGE

36. RACE

37. BIRTH

38. DEATH

39. PLACE

40. CAUSE

41. MANNER

42. SEX

43. AGE

44. RACE

45. BIRTH

46. DEATH

47. PLACE

48. CAUSE

49. MANNER

50. SEX

51. AGE

52. RACE

53. BIRTH

54. DEATH

55. PLACE

56. CAUSE

57. MANNER

58. SEX

59. AGE

60. RACE

61. BIRTH

62. DEATH

63. PLACE

64. CAUSE

65. MANNER

66. SEX

67. AGE

68. RACE

69. BIRTH

70. DEATH

71. PLACE

72. CAUSE

73. MANNER

74. SEX

75. AGE

76. RACE

77. BIRTH

78. DEATH

79. PLACE

80. CAUSE

81. MANNER

82. SEX

83. AGE

84. RACE

85. BIRTH

86. DEATH

87. PLACE

88. CAUSE

89. MANNER

90. SEX

91. AGE

92. RACE

93. BIRTH

94. DEATH

95. PLACE

96. CAUSE

97. MANNER

98. SEX

99. AGE

100. RACE

101. BIRTH

102. DEATH

103. PLACE

104. CAUSE

105. MANNER

106. SEX

107. AGE

108. RACE

109. BIRTH

110. DEATH

111. PLACE

112. CAUSE

113. MANNER

114. SEX

115. AGE

116. RACE

117. BIRTH

118. DEATH

119. PLACE

120. CAUSE

121. MANNER

122. SEX

123. AGE

124. RACE

125. BIRTH

126. DEATH

127. PLACE

128. CAUSE

129. MANNER

130. SEX

131. AGE

132. RACE

133. BIRTH

134. DEATH

135. PLACE

136. CAUSE

137. MANNER

138. SEX

139. AGE

140. RACE

141. BIRTH

142. DEATH

143. PLACE

144. CAUSE

145. MANNER

146. SEX

147. AGE

148. RACE

149. BIRTH

150. DEATH

151. PLACE

152. CAUSE

153. MANNER

154. SEX

155. AGE

156. RACE

157. BIRTH

158. DEATH

159. PLACE

160. CAUSE

161. MANNER

162. SEX

163. AGE

164. RACE

165. BIRTH

166. DEATH

167. PLACE

168. CAUSE

169. MANNER

170. SEX

171. AGE

172. RACE

173. BIRTH

174. DEATH

175. PLACE

176. CAUSE

177. MANNER

178. SEX

179. AGE

180. RACE

181. BIRTH

182. DEATH

183. PLACE

184. CAUSE

185. MANNER

186. SEX

187. AGE

188. RACE

189. BIRTH

190. DEATH

191. PLACE

192. CAUSE

193. MANNER

194. SEX

195. AGE

196. RACE

197. BIRTH

198. DEATH

199. PLACE

200. CAUSE

201. MANNER

202. SEX

203. AGE

204. RACE

205. BIRTH

206. DEATH

207. PLACE

208. CAUSE

209. MANNER

210. SEX

211. AGE

212. RACE

213. BIRTH

214. DEATH

215. PLACE

216. CAUSE

217. MANNER

218. SEX

219. AGE

220. RACE

221. BIRTH

222. DEATH

223. PLACE

224. CAUSE

225. MANNER

226. SEX

227. AGE

228. RACE

229. BIRTH

230. DEATH

231. PLACE

232. CAUSE

233. MANNER

234. SEX

235. AGE

236. RACE

237. BIRTH

238. DEATH

239. PLACE

240. CAUSE

241. MANNER

242. SEX

243. AGE

244. RACE

245. BIRTH

246. DEATH

247. PLACE

248. CAUSE

249. MANNER

250. SEX

251. AGE

252. RACE

253. BIRTH

254. DEATH

255. PLACE

256. CAUSE

257. MANNER

258. SEX

259. AGE

260. RACE

261. BIRTH

262. DEATH

263. PLACE

264. CAUSE

265. MANNER

266. SEX

267. AGE

268. RACE

269. BIRTH

270. DEATH

271. PLACE

272. CAUSE

273. MANNER

274. SEX

275. AGE

276. RACE

277. BIRTH

278. DEATH

279. PLACE

. 11445 CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort George G. Meade</u>		c. LENGTH OF STAY IN 1b <u>19 Days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U. S. Army Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>GEORGE</u> Middle <u>—</u> Last <u>HUBBS</u>		4. DATE OF DEATH Month <u>November</u> Day <u>19</u> Year <u>19 57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11 November 1889</u>
9. AGE (In years last birthday) yrs. <u>68</u>		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Soldier</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>David Hubbs</u>		14. MOTHER'S MAIDEN NAME <u>Isabell Fisher</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>189-16-1580</u>	
17. INFORMANT <u>Daughter, 1816 Patton Drive, Fort Meade, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>332X</u> IMMEDIATE CAUSE (a) <u>Pulmonary Embolus</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Basilar Artery Thrombosis</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>19 Days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1 Nov</u> , 19 <u>57</u> , to <u>19 Nov</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>19 Nov</u> , 19 <u>57</u> , and that death occurred at <u>5:15 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>USAH, Ft. G. G. Meade, Md.</u> DATE SIGNED <u>19 Nov 57</u>			
ACTUAL SIGNATURE <u>John L. Robertson</u>		M.D. <u>USAH, Ft. G. G. Meade, Md.</u>	
PHYSICIAN'S NAME (Type) <u>JOHN L. ROBERTSON, Capt, MC</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 25, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>U. S. National Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Beverly, New Jersey</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph E. Hicks</u>		ADDRESS <u>Elkton, Md</u>	
24a. REC'D BY REGISTRAR <u>Wilbur H. Downs, Jr.</u>		24b. REGISTRAR'S SIGNATURE <u>Wilbur H. Downs, Jr.</u>	
DATE <u>20 Nov 57</u>			

CERTIFICATE OF DEATH

NOV 27 1957

1. NAME OF DECEASED BURKAU V. S.		2. SEX M		3. AGE 68		4. DATE OF BIRTH NOV 27 1957		5. PLACE OF BIRTH MASSACHUSETTS		6. OCCUPATION RETIRED	
7. CAUSE OF DEATH HEART DISEASE		8. MANNER OF DEATH NATURAL		9. PLACE OF DEATH HOME		10. TIME OF DEATH 10:00 AM		11. SIGNATURE OF PHYSICIAN DR. J. H. BROWN		12. SIGNATURE OF REGISTRAR JOHN A. BROWN	
13. NAME OF NEXT OF KIN JOHN A. BROWN		14. ADDRESS OF NEXT OF KIN 123 MAIN ST. BOSTON, MASS.		15. TELEPHONE NUMBER 555-1234		16. DATE OF DEATH NOV 27 1957		17. TIME OF DEATH 10:00 AM		18. SIGNATURE OF PHYSICIAN DR. J. H. BROWN	
19. NAME OF NEXT OF KIN JOHN A. BROWN		20. ADDRESS OF NEXT OF KIN 123 MAIN ST. BOSTON, MASS.		21. TELEPHONE NUMBER 555-1234		22. DATE OF DEATH NOV 27 1957		23. TIME OF DEATH 10:00 AM		24. SIGNATURE OF PHYSICIAN DR. J. H. BROWN	
25. NAME OF NEXT OF KIN JOHN A. BROWN		26. ADDRESS OF NEXT OF KIN 123 MAIN ST. BOSTON, MASS.		27. TELEPHONE NUMBER 555-1234		28. DATE OF DEATH NOV 27 1957		29. TIME OF DEATH 10:00 AM		30. SIGNATURE OF PHYSICIAN DR. J. H. BROWN	

RECEIVED
NOV 27 1957
BURKAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11446 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11449

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jones Station, Severna Park 24 hrs.		c. LENGTH OF STAY IN lb 24 hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Round Up Motel, Ritchie Highway				d. STREET ADDRESS 1501 Ramsey Street			
3. NAME OF DECEASED (Type or print) First Middle Last John P. Ingrassia INGRASSIA				4. DATE OF DEATH Month Day Year Nov. 25th, 1957 19			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/3/08		9. AGE (In years last birthday) 49 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Burner		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) New York, N.Y.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank Ingrassia				14. MOTHER'S MAIDEN NAME Josephine LaGranda			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes 11 world War		16. SOCIAL SECURITY NO. 419-07-488		17. INFORMANT Address Mr. Joseph Ingrassia, (brother)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Gustave H. Faubert				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) Gustave H. Faubert, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 29 Nov 1957		22c. NAME OF CEMETERY OR CREMATORY Holy Cross		22d. LOCATION (City, town, or county) (State) Ad Co Md	
23. FUNERAL DIRECTOR'S SIGNATURE Robert M. Walters				ADDRESS Pratt & Strickland		24a. REC'D BY REGISTRAR NOV 29 1957	
				24b. REGISTRAR'S SIGNATURE L. J. Sealby			

FOR STATE
DEATH REG.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	

BUREAU V. S.

NOV 28 1937

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1145028

11447

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville, Md.		c. LENGTH OF STAY IN 1b 8mos. 15 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		3. NAME OF DECEASED (Type or print) First Robert Middle Jackson Last Jackson	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital, Md.		d. STREET ADDRESS Unknown	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		4. DATE OF DEATH Month 11 Day 19 Year 19 57	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> ? DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unknown
9. AGE (In years last birthday) 45?		IF UNDER 1 YEAR Months 11 Days 19 Hours 57 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) Unknown		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ? (If yes, give war or dates of service) ?		16. SOCIAL SECURITY NO. 213-07-5620	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 023X IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO (b) Hypertensive Heart Disease (c) Status Epilepticus. Late latent Syphilis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X Chronic Brain Disease associated with Arteriosclerosis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 4 , 19 57 , to November 19 , 19 57 , that I last saw the deceased alive on November 19 , 19 57 , and that death occurred at 7:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 11/22/57			
ACTUAL SIGNATURE [Signature]		M.D. Crownsville, Md.	
PHYSICIAN'S NAME (Type) L. Benedict, M. D.		Crownsville State Hospital, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) 11/27/57		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Volund-Wood-Salove		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE William Reese #108 W. Washington St.		24a. REC'D BY REGISTRAR DATE 12/1/57	
24b. REGISTRAR'S SIGNATURE [Signature]			

BUREAU V. S.

DEC 3 1955

RECEIVED

11405
CERTIFICATE OF DEATH

Reg. Dist. 11451

1. PLACE OF DEATH a. COUNTY <i>A. A. County</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>A. A.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) <i>A. A. General Hospital</i>		d. STREET ADDRESS <i>1</i>	
3. NAME OF DECEASED (Type or print) <i>Chene</i> First <i>Gones</i> Middle Last		4. DATE OF DEATH Month <i>11</i> Day <i>5</i> Year <i>1957</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Colored</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7-3-1896</i>
9. AGE (In years last birthday) yrs. <i>61</i>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>William Johnson</i>		14. MOTHER'S MAIDEN NAME <i>Susie Bettes</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Susie Cook</i> Address <i>1954 West Street</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>11-6-57</i> , 19 <i>57</i> , to <i>11-6-57</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>11-6-57</i> , 19 <i>57</i> , and that death occurred at <i>10:45</i> P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>G. L. Cook</i>		ADDRESS (Street, city or town, state) <i>61 Lochvale</i> DATE SIGNED <i>11-11-57</i>	
PHYSICIAN'S NAME (Type) <i>A. T. ALLEN</i>		<i>Annapha Amy</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>11-10-1957</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Mt. Subo</i>	22d. LOCATION (City, town, or county) (State) <i>Chesterfield Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>William Reese</i> ADDRESS <i>10814 West St. Anna, Md.</i>		24a. REC'D BY REGISTRAR <i>Nov 12 1957</i>	24b. REGISTRAR'S SIGNATURE <i>Wm French</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 12 1957

RECEIVED

11448 CERTIFICATE OF DEATH

11452

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville, Md.				c. LENGTH OF STAY IN 1b 11yr, 11mo, 4da.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital, Md.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. STREET ADDRESS 154 East Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle Jones Last Jones				4. DATE OF DEATH Month November Day 5 Year 19 57			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/7/1890	
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months 67 Days 0 Hours 0 Min. 0		IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Harry Jones				14. MOTHER'S MAIDEN NAME Mary Sand			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. W. W. I		17. INFORMANT Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure, and Syphilis 025x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Electrolyte Deficiency DUE TO (c) Post-operation for Carcinoma of Rectum				INTERVAL BETWEEN ONSET AND DEATH October, 1957			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Paranoid Condition				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----			
20c. TIME OF INJURY Month, Day, Year Hour a. m. ----- 19 p. m. -----				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	
20f. (City or town) -----				20g. (County) -----		20h. (State) -----	
21. I certify that I attended the deceased from December 1, 1945 , to November 5, 1957 , that I last saw the deceased alive on November 5, 1957 , and that death occurred at 9:00 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>[Signature]</i>				ADDRESS (Street, city or town, state) Crownsville, Md.			
DATE SIGNED 11/6/57							
PHYSICIAN'S NAME (Type) L. Benedict, M. D.				Crownsville State Hospital, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-15-57		22c. NAME OF CEMETERY OR CREMATORY Crownsville, Md.		22d. LOCATION (City, town, or county) (State) Crownsville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>[Signature]</i>				ADDRESS Crownsville State Hospital, Crownsville, Md.		24a. REC'D BY REGISTRAR 11/8/57	
24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

1957 60 AC.

BUREAU V. 5

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11449 CERTIFICATE OF DEATH

Reg. Dist. No.

11453

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manhattan Beach, Syx</u>		c. LENGTH OF STAY IN 1b <u>1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John T. Kelbey</u>		4. DATE OF DEATH <u>11-15-57</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 28, 1865</u>
9. AGE (In years last birthday) <u>92</u> yrs.		10. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Squad</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Police</u>	
11. BIRTHPLACE (State or foreign country) <u>Glyndon Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Wm Kelbey</u>		14. MOTHER'S MAIDEN NAME <u>Mary J. Bowen</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-07-3671</u>	
17. INFORMANT <u>Daughter Mrs. Brewer Manhattan Beach</u>		Address <u>Manhattan Beach</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure.</u> 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis.</u> DUE TO (c) <u>Senility.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>450.0</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 57, 19</u> , to <u>Nov</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Sept 15, 1957</u> , and that death occurred at <u>6 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert R. Hahn</u> M.D.		ADDRESS (Street, city or town, state) <u>Severna Park Md</u>	
PHYSICIAN'S NAME (Type) <u>R. HAHN</u>		DATE SIGNED <u>11-15-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 18/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u>		22d. LOCATION (City, town, or county) (State) <u>Pikesville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.F. Eline & Sons, Reisterstown, Md.</u>		24. REC'D BY REGISTRAR <u>11-15-57</u>	
24b. REGISTRAR'S SIGNATURE <u>J. J. DeLap</u>			

CERTIFICATE OF DEATH

PART I. DEATH		PART II. CAUSE OF DEATH	
1. NAME OF DECEASED		2. PLACE OF DEATH	
3. SEX		4. AGE	
5. DATE OF DEATH		6. TIME OF DEATH	
7. PLACE OF BIRTH		8. OCCUPATION	
9. MARITAL STATUS		10. EDUCATION	
11. PRESENT RESIDENCE		12. PREVIOUS RESIDENCE	
13. DATE OF ENTRY INTO STATE		14. DATE OF ENTRY INTO COUNTRY	
15. DATE OF ENTRY INTO CITY		16. DATE OF ENTRY INTO COUNTY	
17. DATE OF ENTRY INTO DISTRICT		18. DATE OF ENTRY INTO STATE	
19. DATE OF ENTRY INTO COUNTRY		20. DATE OF ENTRY INTO CITY	
21. DATE OF ENTRY INTO COUNTY		22. DATE OF ENTRY INTO DISTRICT	
23. DATE OF ENTRY INTO STATE		24. DATE OF ENTRY INTO COUNTRY	
25. DATE OF ENTRY INTO CITY		26. DATE OF ENTRY INTO COUNTY	
27. DATE OF ENTRY INTO DISTRICT		28. DATE OF ENTRY INTO STATE	
29. DATE OF ENTRY INTO COUNTRY		30. DATE OF ENTRY INTO CITY	
31. DATE OF ENTRY INTO COUNTY		32. DATE OF ENTRY INTO DISTRICT	
33. DATE OF ENTRY INTO STATE		34. DATE OF ENTRY INTO COUNTRY	
35. DATE OF ENTRY INTO CITY		36. DATE OF ENTRY INTO COUNTY	
37. DATE OF ENTRY INTO DISTRICT		38. DATE OF ENTRY INTO STATE	
39. DATE OF ENTRY INTO COUNTRY		40. DATE OF ENTRY INTO CITY	
41. DATE OF ENTRY INTO COUNTY		42. DATE OF ENTRY INTO DISTRICT	
43. DATE OF ENTRY INTO STATE		44. DATE OF ENTRY INTO COUNTRY	
45. DATE OF ENTRY INTO CITY		46. DATE OF ENTRY INTO COUNTY	
47. DATE OF ENTRY INTO DISTRICT		48. DATE OF ENTRY INTO STATE	
49. DATE OF ENTRY INTO COUNTRY		50. DATE OF ENTRY INTO CITY	
51. DATE OF ENTRY INTO COUNTY		52. DATE OF ENTRY INTO DISTRICT	
53. DATE OF ENTRY INTO STATE		54. DATE OF ENTRY INTO COUNTRY	
55. DATE OF ENTRY INTO CITY		56. DATE OF ENTRY INTO COUNTY	
57. DATE OF ENTRY INTO DISTRICT		58. DATE OF ENTRY INTO STATE	
59. DATE OF ENTRY INTO COUNTRY		60. DATE OF ENTRY INTO CITY	
61. DATE OF ENTRY INTO COUNTY		62. DATE OF ENTRY INTO DISTRICT	
63. DATE OF ENTRY INTO STATE		64. DATE OF ENTRY INTO COUNTRY	
65. DATE OF ENTRY INTO CITY		66. DATE OF ENTRY INTO COUNTY	
67. DATE OF ENTRY INTO DISTRICT		68. DATE OF ENTRY INTO STATE	
69. DATE OF ENTRY INTO COUNTRY		70. DATE OF ENTRY INTO CITY	
71. DATE OF ENTRY INTO COUNTY		72. DATE OF ENTRY INTO DISTRICT	
73. DATE OF ENTRY INTO STATE		74. DATE OF ENTRY INTO COUNTRY	
75. DATE OF ENTRY INTO CITY		76. DATE OF ENTRY INTO COUNTY	
77. DATE OF ENTRY INTO DISTRICT		78. DATE OF ENTRY INTO STATE	
79. DATE OF ENTRY INTO COUNTRY		80. DATE OF ENTRY INTO CITY	
81. DATE OF ENTRY INTO COUNTY		82. DATE OF ENTRY INTO DISTRICT	
83. DATE OF ENTRY INTO STATE		84. DATE OF ENTRY INTO COUNTRY	
85. DATE OF ENTRY INTO CITY		86. DATE OF ENTRY INTO COUNTY	
87. DATE OF ENTRY INTO DISTRICT		88. DATE OF ENTRY INTO STATE	
89. DATE OF ENTRY INTO COUNTRY		90. DATE OF ENTRY INTO CITY	
91. DATE OF ENTRY INTO COUNTY		92. DATE OF ENTRY INTO DISTRICT	
93. DATE OF ENTRY INTO STATE		94. DATE OF ENTRY INTO COUNTRY	
95. DATE OF ENTRY INTO CITY		96. DATE OF ENTRY INTO COUNTY	
97. DATE OF ENTRY INTO DISTRICT		98. DATE OF ENTRY INTO STATE	
99. DATE OF ENTRY INTO COUNTRY		100. DATE OF ENTRY INTO CITY	

BUREAU V. S.

NOV 19 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registering office prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11450

CERTIFICATE OF DEATH

Reg. Dist. No.

114544

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY AA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN 1b 4 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 306 W. Furnace Branch Road		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Glen Burnie,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 306 W. Furnace Branch Road		d. STREET ADDRESS 306 W. Furnace Branch Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Carroll Middle Jay Last Klob		4. DATE OF DEATH Month Nov. Day 29 Year 1957	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 29, 1957
9. AGE (In years last birthday) yrs. 4		IF UNDER 1 YEAR Months 4 Days Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 		10b. KIND OF BUSINESS OR INDUSTRY 	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Klob		14. MOTHER'S MAIDEN NAME Margeret Redman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT William Klob,		Address same as 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia Secondary to Vomiting DUE TO (b) Acute Epidemic Gastro enteritis DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH immediate 4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/28/57 , 19 57 , to 11/29/57 , 19 57 , that I last saw the deceased alive on 11/29/57 , 19 57 , and that death occurred at 239 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Leonard H. Flax, M.D.		ADDRESS (Street, city or town, state) 113 7th Ave Brooklyn Park DATE SIGNED 11/30/57	
PHYSICIAN'S NAME (Type) Leonard H. Flax, M.D.		113 7th Ave. Baltimore 25, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 2, 1957	
22c. NAME OF CEMETERY OR CREMATORY Meadowridge		22d. LOCATION (City, town, or county) (State) Howard County Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Hopping and Kirkley, Glen Burnie, Md.		24a. REC'D BY REGISTRAR DEC 2 1957	
24b. REGISTRAR'S SIGNATURE J. Adley			

2049273 XV4

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES A. BROWN		2. SEX Male		3. AGE 45		4. DATE OF DEATH Dec 1, 1957	
5. PLACE OF BIRTH Baltimore, Md.		6. OCCUPATION Salesman		7. MARITAL STATUS Married		8. CAUSE OF DEATH Heart Disease	
9. PLACE OF DEATH Home		10. SIGNATURE OF DECEASED (Signature)		11. SIGNATURE OF WITNESS (Signature)		12. SIGNATURE OF PHYSICIAN (Signature)	
13. PLACE OF BURIAL Catholic Cemetery		14. NAME OF CEMETERY Catholic Cemetery		15. NAME OF MINISTER Rev. J. J. Smith		16. NAME OF CLERGYMAN Rev. J. J. Smith	
17. NAME OF FUNERAL HOME Brown & Sons		18. NAME OF FUNERAL HOME Brown & Sons		19. NAME OF FUNERAL HOME Brown & Sons		20. NAME OF FUNERAL HOME Brown & Sons	
21. NAME OF FUNERAL HOME Brown & Sons		22. NAME OF FUNERAL HOME Brown & Sons		23. NAME OF FUNERAL HOME Brown & Sons		24. NAME OF FUNERAL HOME Brown & Sons	
25. NAME OF FUNERAL HOME Brown & Sons		26. NAME OF FUNERAL HOME Brown & Sons		27. NAME OF FUNERAL HOME Brown & Sons		28. NAME OF FUNERAL HOME Brown & Sons	
29. NAME OF FUNERAL HOME Brown & Sons		30. NAME OF FUNERAL HOME Brown & Sons		31. NAME OF FUNERAL HOME Brown & Sons		32. NAME OF FUNERAL HOME Brown & Sons	
33. NAME OF FUNERAL HOME Brown & Sons		34. NAME OF FUNERAL HOME Brown & Sons		35. NAME OF FUNERAL HOME Brown & Sons		36. NAME OF FUNERAL HOME Brown & Sons	
37. NAME OF FUNERAL HOME Brown & Sons		38. NAME OF FUNERAL HOME Brown & Sons		39. NAME OF FUNERAL HOME Brown & Sons		40. NAME OF FUNERAL HOME Brown & Sons	
41. NAME OF FUNERAL HOME Brown & Sons		42. NAME OF FUNERAL HOME Brown & Sons		43. NAME OF FUNERAL HOME Brown & Sons		44. NAME OF FUNERAL HOME Brown & Sons	
45. NAME OF FUNERAL HOME Brown & Sons		46. NAME OF FUNERAL HOME Brown & Sons		47. NAME OF FUNERAL HOME Brown & Sons		48. NAME OF FUNERAL HOME Brown & Sons	
49. NAME OF FUNERAL HOME Brown & Sons		50. NAME OF FUNERAL HOME Brown & Sons		51. NAME OF FUNERAL HOME Brown & Sons		52. NAME OF FUNERAL HOME Brown & Sons	
53. NAME OF FUNERAL HOME Brown & Sons		54. NAME OF FUNERAL HOME Brown & Sons		55. NAME OF FUNERAL HOME Brown & Sons		56. NAME OF FUNERAL HOME Brown & Sons	
57. NAME OF FUNERAL HOME Brown & Sons		58. NAME OF FUNERAL HOME Brown & Sons		59. NAME OF FUNERAL HOME Brown & Sons		60. NAME OF FUNERAL HOME Brown & Sons	
61. NAME OF FUNERAL HOME Brown & Sons		62. NAME OF FUNERAL HOME Brown & Sons		63. NAME OF FUNERAL HOME Brown & Sons		64. NAME OF FUNERAL HOME Brown & Sons	
65. NAME OF FUNERAL HOME Brown & Sons		66. NAME OF FUNERAL HOME Brown & Sons		67. NAME OF FUNERAL HOME Brown & Sons		68. NAME OF FUNERAL HOME Brown & Sons	
69. NAME OF FUNERAL HOME Brown & Sons		70. NAME OF FUNERAL HOME Brown & Sons		71. NAME OF FUNERAL HOME Brown & Sons		72. NAME OF FUNERAL HOME Brown & Sons	
73. NAME OF FUNERAL HOME Brown & Sons		74. NAME OF FUNERAL HOME Brown & Sons		75. NAME OF FUNERAL HOME Brown & Sons		76. NAME OF FUNERAL HOME Brown & Sons	
77. NAME OF FUNERAL HOME Brown & Sons		78. NAME OF FUNERAL HOME Brown & Sons		79. NAME OF FUNERAL HOME Brown & Sons		80. NAME OF FUNERAL HOME Brown & Sons	
81. NAME OF FUNERAL HOME Brown & Sons		82. NAME OF FUNERAL HOME Brown & Sons		83. NAME OF FUNERAL HOME Brown & Sons		84. NAME OF FUNERAL HOME Brown & Sons	
85. NAME OF FUNERAL HOME Brown & Sons		86. NAME OF FUNERAL HOME Brown & Sons		87. NAME OF FUNERAL HOME Brown & Sons		88. NAME OF FUNERAL HOME Brown & Sons	
89. NAME OF FUNERAL HOME Brown & Sons		90. NAME OF FUNERAL HOME Brown & Sons		91. NAME OF FUNERAL HOME Brown & Sons		92. NAME OF FUNERAL HOME Brown & Sons	
93. NAME OF FUNERAL HOME Brown & Sons		94. NAME OF FUNERAL HOME Brown & Sons		95. NAME OF FUNERAL HOME Brown & Sons		96. NAME OF FUNERAL HOME Brown & Sons	
97. NAME OF FUNERAL HOME Brown & Sons		98. NAME OF FUNERAL HOME Brown & Sons		99. NAME OF FUNERAL HOME Brown & Sons		100. NAME OF FUNERAL HOME Brown & Sons	

BUREAU V. S.

DEC 2 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11455 *ny*

Reg. Dist. No.

11451

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Same</u> b. COUNTY <u>Same</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ferndale</u>		c. LENGTH OF STAY IN TB <u>5 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>309 Orchard Road.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary E. Lamb</u>		4. DATE OF DEATH Month Day Year <u>November 26 19 57</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/16/83</u>
9. AGE (In years lost birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore County, Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Eliza Fisher</u>		14. MOTHER'S MAIDEN NAME <u>Amelia Tracy</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address <u>Mrs. Grace Lawrence (Niece)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hypertensive cardiovascular diseases.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <u>5 y.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 11/25/57</u> , 19 <u>52</u> , to <u>11/26/57</u> , 19 _____, that I last saw the deceased alive on <u>11/25/57</u> , 19 _____, and that death occurred at <u>11 A.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Gustave H. Faubert</u> M.D.		DATE SIGNED <u>11/26/57</u>	
PHYSICIAN'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>		<u>Glen Burnie, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/29/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John T. Stansbury</u>		ADDRESS <u>6411 Windsor Mill</u>	
24a. REC'D BY REGISTRAR <u>DEC 2 1957</u>		24b. REGISTRAR'S SIGNATURE <u>L. J. Dealy</u>	

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12661

11452 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville, Md.</u>				c. LENGTH OF STAY IN 1b <u>1yr, 1mo, 13da.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital, Md.</u>				d. STREET ADDRESS <u>1526 W. Lanvale Street</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Delia</u> Middle <u>Bryant</u> Last <u>Langley</u>				4. DATE OF DEATH Month <u>11</u> Day <u>24</u> Year <u>19 57</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/16/1855</u>		9. AGE (In years last birthday) <u>102</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Daniel Bryant</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Bryant</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -----		16. SOCIAL SECURITY NO. -----		17. INFORMANT <u>Hospital Record</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypostatic Pneumonia</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c) -----		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Arteriosclerosis</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----					
20c. TIME OF INJURY Month, Day, Year Hour a. m. ----- p. m. ----- 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State) -----	
21. I certify that I attended the deceased from <u>October 11, 19 57</u> , to <u>November 24, 19 57</u> , that I last saw the deceased alive on <u>October 11, 19 57</u> , and that death occurred at <u>9:40a</u> AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Lionel McHenry Mapp</u>				ADDRESS (Street, city or town, state) <u>Crownsville, Md.</u>		DATE SIGNED <u>11/25/57</u>	
PHYSICIAN'S NAME (Type) <u>Lionel McHenry Mapp, M. D.</u>				<u>Crownsville State Hospital, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>12.4.57</u>		22b. DATE THEREOF <u>12.4.57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Crownsville State Hospital</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Kase #108 Wash St. Crownsville, Md.</u>				24a. REC'D BY REGISTRAR <u>12/9/57</u>		24b. REGISTRAR'S SIGNATURE <u>R. M. Joyce</u>	

BUREAU V. S.

DEC 10 1957

RECEIVED

11453 CERTIFICATE OF DEATH

11456 24

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena R.F.D. Green Haven 10 Yrs</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena R.F.D. Green Haven X2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>East Shore Road@ Seventh Street</u>				d. STREET ADDRESS <u>East Shore Road@ Seventh</u>			
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>J</u> Last <u>Laudermilk</u>				4. DATE OF DEATH Month <u>November</u> Day <u>4</u> Year <u>19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 1878</u>	9. AGE (In years last birthday) yrs. <u>79</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer (Ret)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self Emp.</u>		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Allen Laudermilk</u>				14. MOTHER'S MAIDEN NAME <u>Rose Ann (Unknown)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asian influenza</u> <u>481X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Arteriosclerotic cardio-vascular disease</u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>several years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Paralysis agitans - several years</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u> </u> <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan. 15</u> , 19 <u>54</u> , to <u>Nov. 4</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Nov. 3</u> , 19 <u>57</u> , and that death occurred at <u>11:45 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. M. McLaughlin</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>Nov. 4, 1957</u>			
PHYSICIAN'S NAME (Type) <u>R. M. McLaughlin</u>				M.D. <u>R.F.D. 8 Box 442 Pasadena, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 7, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Brooklyn RFD Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. M. McLaughlin</u>				ADDRESS <u>Ill. Bunnis - Md.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 12 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>L. J. Sealbap</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100

BUREAU V. S.

NOV 12 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11457

11406

CERTIFICATE OF DEATH

Reg. Dist. No.

21

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Annapolis	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First AMANDA Middle LEWIS Last		4. DATE OF DEATH Month NOVEMBER Day 14 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 21, 1888
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house wife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Annapolis, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thaddius T. Lockett		14. MOTHER'S MAIDEN NAME Mary Ellen Britton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT John L. Anderton- Son- same as # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Left ventricular failure due to 411X DUE TO Arteric Stenosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) rheumatic heart disease (c) arteriosclerosis, nephrosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) arteriosclerosis, nephrosclerosis INTERVAL BETWEEN ONSET AND DEATH 10 y			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-4 , 19 53 , to 11-14 , 19 57 , that I last saw the deceased alive on 11-14 , 19 57 , and that death occurred at 6:25 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 45 Franklin St. Annapolis DATE SIGNED 11-16-57 ACTUAL SIGNATURE Edith Rodler M.D. 45 Franklin St. Annapolis PHYSICIAN'S NAME (Type) Edith Rodler MD 45 Franklin Street, Annapolis, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-18-57	
22c. NAME OF CEMETERY OR CREMATORY Cedar Bluff Cemetery		22d. LOCATION (City, town, or county) (State) Annapolis, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home		ADDRESS Annapolis, Md.	
24a. REC'D BY REGISTRAR NOV 19 1957		24b. REGISTRAR'S SIGNATURE M. J. French	

CERTIFICATE OF DEATH

PLACE OF DEATH		MARRIAGE	
Home		No	
Date of Death		Date of Marriage	
11-10-57		11-10-57	
Time of Death		Time of Marriage	
10:00 AM		10:00 AM	
Cause of Death		Cause of Marriage	
Heart Disease		Love	
1. Myocardial Infarction		1. Myocardial Infarction	
2. Atherosclerosis		2. Atherosclerosis	
3. Hypertension		3. Hypertension	
4. Coronary Artery Disease		4. Coronary Artery Disease	
5. Other		5. Other	
6. Unknown		6. Unknown	
7. Suicide		7. Suicide	
8. Homicide		8. Homicide	
9. Natural Causes		9. Natural Causes	
10. Other		10. Other	
11. Unknown		11. Unknown	
12. Other		12. Other	
13. Unknown		13. Unknown	
14. Other		14. Other	
15. Unknown		15. Unknown	
16. Other		16. Other	
17. Unknown		17. Unknown	
18. Other		18. Other	
19. Unknown		19. Unknown	
20. Other		20. Other	

RECEIVED
NOV 19 1957
BUREAU V. S.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11458

11454

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

24

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u>		c. LENGTH OF STAY IN 1b <u>7 months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Riverdale Rd.</u>				d. STREET ADDRESS <u>Same</u>			
3. NAME OF DECEASED (Type or print) <u>Sharron Lee Lucas</u>				4. DATE OF DEATH Nov. 23 1957			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/23/57</u>		9. AGE (In years last birthday) <u>7</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>7</u> Hours <u>7</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Annapolis, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Vernon Lucas</u>				14. MOTHER'S MAIDEN NAME <u>Esther C. Calhoun</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>William V. Lucas (father)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PURULENT OTITIS MEDIA-LEFT.</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>R.S. Fisher</u> EXAMINER'S NAME (Type) <u>R.S. FISHER</u>				M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/26/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping & Kirkley,</u>				ADDRESS <u>Glen Burnie, Md.</u>		24. FILED BY REGISTRAR DATE <u>NOV 29 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>L.J. Deakins</u>							

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NOV 29 1957

BUREAU V. S.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11455

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11459

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GLEN BURNIE</u>		c. LENGTH OF STAY IN 1b <u>23 YEARS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GLEN BURNIE, RFD, MARLEY PARK X2</u>		d. STREET ADDRESS <u>#112 FORREST RD.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>#112 FORREST RD., MARLEY PARK</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>PERRY OLIVER MARSH</u>				4. DATE OF DEATH Month Day Year <u>NOVEMBER 1, 19 57</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUGUST 4, 1887</u>		9. AGE (In years last birthday) <u>70</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LONGSHOREMAN (Ret.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>I.L.A., BALTO.</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE CO., MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>PERRY MARSH</u>				14. MOTHER'S MAIDEN NAME <u>OCTAVIA BOWAN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT <u>MRS. LOUISE SCHOOLMAN</u> Address <u>113 Forrest Rd. Glen Burnie RFD, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diabetes</u> <u>260x</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>General Arteriosclerosis</u> (c) <u>General Arteriosclerosis</u> DUE TO (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH <u>?</u> <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				<u>11/3/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>Nov. 4/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. James</u>		22d. LOCATION (City, town, or county) (State) <u>My Lady's Manor, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Richard V. Slight</u>				24a. REC'D BY REGISTRAR <u>Alvin Burnie, M.D.</u>			
				24b. REGISTRAR'S SIGNATURE <u>L. J. Adley</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

NOV 9 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11460

11456

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Odenton</u>				c. LENGTH OF STAY IN 1b <u>6 Yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Odenton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Patuxent Road</u>				d. STREET ADDRESS <u>Patuxent Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>M.</u> Last <u>Martz Jr.</u>				4. DATE OF DEATH Month <u>November</u> Day <u>4</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 30, 1864</u>		9. AGE (In years lost birthday) <u>92</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer (Ret)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self Emp.</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George N. Martz</u>				14. MOTHER'S MAIDEN NAME <u>Sarah (Unknown)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>None</u>		17. INFORMANT Address <u>James M. Martz Jr. Patuxent Rd. Odenton</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-Vascular Disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Atherosclerosis</u> DUE TO (c) <u>Prostatitis & Cystitis & Pyelitis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u> <u>8-10 yrs.</u> <u>10 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>year - 1949</u> , to <u>11/4/57</u> , 19____, that I last saw the deceased alive on <u>11/4/57</u> , 19____, and that death occurred at <u>2 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Chas. L. Ball</u>				ADDRESS (Street, city or town, state) <u>Glen Burnie, Maryland</u>		DATE SIGNED <u>11/6/57</u>	
PHYSICIAN'S NAME (Type) _____ M.D. <u>Lanthier</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 7, 57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Light</u>				ADDRESS <u>Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 12 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Cara Asbury</u>			

CERTIFICATE OF DEATH

1956

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

NAME OF DECEASED		DATE OF DEATH	
PLACE OF DEATH		TIME OF DEATH	
AGE		SEX	
RACE		RELIGION	
MARRIAGE		EDUCATION	
OCCUPATION		CAUSE OF DEATH	
MANNER OF DEATH		PLACE OF BURIAL	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE OF SIGNATURE		DATE OF SIGNATURE	

BUREAU V. S.

NOV 12 1957

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11461 *24*

Reg. Dist. No.

11457

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena (Magothy Beach)</u>		c. LENGTH OF STAY IN 1b <u>2 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Box 179A Riverside Drive</u>				d. STREET ADDRESS <u>Same</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Casper Joseph Miller</u>				4. DATE OF DEATH Month <u>November</u> Day <u>28th</u> Year <u>19 57</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/15/04</u>		9. AGE (In years last birthday) <u>52 yrs.</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chauffeur</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Miller</u>				14. MOTHER'S MAIDEN NAME <u>Theresa Slack</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-01-2077</u>		17. INFORMANT <u>Mrs. Rose Miller (wife)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> (c) <u> </u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Gustave H. Faubert</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>Gustave H. Faubert M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <u>XX</u>		<u>11/28/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 2, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sacred Heart of Jesus Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>German Hill Road</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond L. Keczyrowski</u>				ADDRESS <u>2525 Fleet St.</u>		24a. REC'D BY REGISTRAR <u>DEC 5 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>L. J. Hedley</u>			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
DEC 5 1957
BUREAU V. 3

11-137

1. NAME OF DECEASED: _____

2. SEX: ☐ MALE ☐ FEMALE

3. AGE: _____

4. DATE OF BIRTH: _____

5. PLACE OF BIRTH: _____

6. OCCUPATION: _____

7. MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED

8. PRESENT ADDRESS: _____

9. DATE OF DEATH: _____

10. TIME OF DEATH: _____

11. PLACE OF DEATH: _____

12. CAUSE OF DEATH: _____

13. MANNER OF DEATH: ☐ NATURAL ☐ ACCIDENTAL ☐ SUICIDE ☐ HOMICIDE ☐ UNDETERMINED

14. SIGNATURE OF MEDICAL EXAMINER: _____

15. SIGNATURE OF WITNESS: _____

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11462

11407

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>10</u> <u>Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Homewood Convalescent Home</u>		d. STREET ADDRESS <u>158 Conduit St.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>B.</u> Last <u>Miller</u>		4. DATE OF DEATH Month <u>November</u> Day <u>29</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 23, 1970</u>
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Postal Supervisor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov't.</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Adam Miller</u>		14. MOTHER'S MAIDEN NAME <u>Jennie Lininger</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>DRAVISH</u>		16. SOCIAL SECURITY NO. <u>12-3-57</u>	
17. INFORMANT <u>Mrs. Helen M. Hillman</u> Address <u>#2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary heart failure</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic obstructive cardiopulmonary disease</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u> <u>20 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>56</u> , to <u>Nov 29</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Nov 26</u> , 19 <u>57</u> , and that death occurred at <u>12:30</u> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John H. Hillman</u> M.D.		ADDRESS (Street, city or town, state) <u>Annapolis Md.</u> DATE SIGNED <u>11/29/57</u>	
PHYSICIAN'S NAME (Type) <u></u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-3-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>LAUREL MEMORIAL PK.</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis City Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. G. & Sons</u>		ADDRESS <u>Annapolis Md.</u>	
24a. REC'D BY REGISTRAR <u>U. O. H. H. H.</u>		24b. REGISTRAR'S SIGNATURE <u>U. O. H. H. H.</u>	
DATE <u>12/3/57</u>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. COLOR	
9. DATE OF DEATH		10. TIME OF DEATH		11. PLACE OF DEATH		12. CAUSE OF DEATH		13. MANNER OF DEATH		14. MEDICAL HISTORY		15. PREVIOUS ILLNESS		16. SIGNATURE OF PHYSICIAN	
17. SIGNATURE OF REGISTRAR		18. SIGNATURE OF WITNESS		19. SIGNATURE OF CLERK		20. SIGNATURE OF JUDGE		21. SIGNATURE OF SHERIFF		22. SIGNATURE OF CORONER		23. SIGNATURE OF DEPUTY		24. SIGNATURE OF ASSISTANT	

BUREAU V. 2

DEC 4 1957

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The body copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11463

CERTIFICATE OF DEATH

1408

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>A.A.</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Annapolis</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Churchton</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Arundel General Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) WILLIAM FRANK MILLER				4. DATE OF DEATH (Month) (Day) (Year) Nov 18, 1957			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Nov 18, 1885</u>	9. AGE last birthday <u>72</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Police man</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Met Police retiree</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>yes</u> <u>Peace time</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT & ADDRESS <u>William F. Miller - Son</u> <u>2209 Jamieson St. Hill Crest Heights Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
491X IMMEDIATE CAUSE (A) ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)				Interval BETWEEN ONSET AND DEATH <u>3 d.</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Myocardial infarction</u>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11-5-57</u> , to <u>11-18-57</u> , that I last saw the deceased alive on <u>11-18-57</u> , and that death occurred at <u>10 P.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Frank M. Shipley</u>				ADDRESS (Street, city, town, state) <u>M.D. 63 College Ave. Annapolis Md 21403</u>		DATE SIGNED <u>11/19/57</u>	
23. BURIAL, CREMATION, REMOVAL, (SPECIFY) <u>Burial</u>	DATE THEREOF <u>11-22-57</u>	NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem.</u>		LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>			
24. REC'D BY REGISTRAR <u>NOV 25 1957</u>	REGISTRAR'S SIGNATURE <u>Wm J French</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co. Washington, D.C.</u>		ADDRESS		

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

NOV 25 1957

RECEIVED

BUREAU V. 1

INSTRUCTIONS

1. This form is to be filled out by the physician or other qualified person who has attended the deceased. It should be filled out as soon as possible after death, and before the body is buried or cremated. It is a legal document and its contents are subject to inspection by the State Department of Health.

2. The information on this form is used for the purpose of determining the cause of death and for the purpose of compiling statistics on the health of the State.

3. The information on this form is also used for the purpose of determining the eligibility of the deceased for certain benefits, such as life insurance and Social Security.

4. The information on this form is also used for the purpose of determining the eligibility of the deceased for certain services, such as medical care and nursing home care.

5. The information on this form is also used for the purpose of determining the eligibility of the deceased for certain programs, such as the State Death Benefit Program.

6. The information on this form is also used for the purpose of determining the eligibility of the deceased for certain other programs, such as the State Funeral Benefit Program.

7. The information on this form is also used for the purpose of determining the eligibility of the deceased for certain other services, such as the State Burial Benefit Program.

8. The information on this form is also used for the purpose of determining the eligibility of the deceased for certain other programs, such as the State Cremation Benefit Program.

9. The information on this form is also used for the purpose of determining the eligibility of the deceased for certain other services, such as the State Interment Benefit Program.

10. The information on this form is also used for the purpose of determining the eligibility of the deceased for certain other programs, such as the State Burial Benefit Program.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11464

11458

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
c. LENGTH OF STAY IN 1b 6ys, 9mo, 19da.		d. STREET ADDRESS 601 S. Paca Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Alice Middle Moody Last Moody		4. DATE OF DEATH Month 11 Day 24 Year 19 57	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/9/77
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months 11 Days 24 Hours 19 Min. 57	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Landy Moody		14. MOTHER'S MAIDEN NAME Anne Olivia Hardey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -----		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Hospital Record		Address -----	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Insufficiency 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial Infarction DUE TO (c) Arteriosclerotic - Cardiovascular Disease			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile Psychosis			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) -----		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour a. m. ----- p. m. ----- 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State) -----	
21. I certify that I attended the deceased from January 5, 19 51 , to November 24, 19 57 , that I last saw the deceased alive on November 24, 19 57 , and that death occurred at 1:30 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Lionel McHenry Mapp		ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 11/25/57	
PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.		Crownsville State Hospital, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/27/57	22c. NAME OF CEMETERY OR CREMATORY Mount Auburn	22d. LOCATION (City, town, or county) (State) Baltimore Md
23. FUNERAL DIRECTOR'S SIGNATURE Charles A. Pace		ADDRESS 661 W. Bond St	
24a. REC'D BY REGISTRAR 11/29/57		24b. REGISTRAR'S SIGNATURE J. M. Joyce	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
RUBEN J. BROWN		MALE		35		JAN 15 1922	
PLACE OF BIRTH		RACE		OCCUPATION		EDUCATION	
BALTIMORE, MARYLAND		WHITE		LABORER		HIGH SCHOOL	
MANNER OF DEATH		CAUSE OF DEATH		PERIOD OF ILLNESS		PLACE OF DEATH	
SUICIDE		HEART DISEASE		2 WEEKS		HOME	
DATE OF DEATH		TIME OF DEATH		TEMPERATURE		PULSE	
DEC 2 1957		10:00 PM		101.0 F		60 BPM	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED		SIGNATURE OF FUNERAL HOME	
[Signature]		[Signature]		[Signature]		[Signature]	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
DEC 2 1957		DEC 2 1957		DEC 2 1957		DEC 2 1957	

BUREAU V. S.

DEC 3 1957

RECEIVED

11459

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gambrills</u>				c. LENGTH OF STAY IN 1b <u>28 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crain Highway</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>TIMOTHY</u> Middle <u>A.</u> Last <u>O'KEEFE</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>13</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 2 10/1876</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer (ret.)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u>		11. BIRTHPLACE (State or foreign country) <u>Ireland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Michael O'Keefe</u>				14. MOTHER'S MAIDEN NAME <u>Johanna Donovan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give year or date of service) <u>11/11/11</u>				16. SOCIAL SECURITY NO. <u> </u>			
17. INFORMANT <u>Mr. Louis O'Keefe</u>				Address <u>Same As #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>General Arteriosclerosis</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs. 4</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>January, 1952</u> , to <u>Nov. 13, 1957</u> , that I last saw the deceased alive on <u>Nov. 8, 1957</u> , and that death occurred at <u>2:40</u> A. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Gustave H. Faubert</u> M.D. <u>Glen Burnie, Maryland</u>							
PHYSICIAN'S NAME (Type) <u>Gustave H. Faubert</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 15/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Our Lady of the Field Millersville, Md.</u>		22d. LOCATION (City, town, or county) (State) <u>Nov. 14/57</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>G. M. Jones</u>				ADDRESS <u>Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 18 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>G. M. Jones</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		35		M		W		1928		MOBILE, ALABAMA	
RESIDENCE		OCCUPATION		EDUCATION		MARRIAGE		DATE OF DEATH		PLACE OF DEATH	
1000 E. MONROE ST., BALTIMORE, MD.		ATTORNEY AT LAW		HIGH SCHOOL		MARRIED		1957		BALTIMORE, MD.	
CAUSE OF DEATH		MANNER OF DEATH		MEDICAL ATTENDANCE		POST-MORTEM		CORONER'S OFFICE		JURY	
HEART DISEASE		NATURAL CAUSE		YES		NO		YES		NO	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH	
11/18/57		10:00 AM		HOME		11/18/57		10:00 AM		HOME	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF JURY		SIGNATURE OF DECEASED	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	

BUREAU V. S.

NOV 18 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11460 CERTIFICATE OF DEATH

11466

Reg. Dist. No. 24

1. PLACE OF DEATH a. COUNTY <u>Ann a Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>A. A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bar Harbor</u>		c. LENGTH OF STAY IN 1b <u>50 yrs</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>24</u>		d. STREET ADDRESS <u>524 S. Lakewood Ave.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Johnson Rd. Pasadena Md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>THOMAS</u> Middle <u>KOLBJORN</u> Last <u>OLSEN</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>3</u> Year <u>1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 25. 1888</u>
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chief Mate, Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Marine Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>30Yrs. Norway</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Christian Olsen</u>		14. MOTHER'S MAIDEN NAME <u>Andrea Knutsen</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>John Olsen.</u>		Address <u>524 S. Lakewood Ave. 24</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Stomach</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a. <u> </u> p. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I attended the deceased from <u>JULY 19, 1957</u> to <u>11/4</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11/2</u> , 19 <u>57</u> , and that death occurred at <u>12:17</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. Brady Smith</u>		ADDRESS (Street, city or town, state) <u>RIVIERA BEACH</u>	
PHYSICIAN'S NAME (Type) <u>J. BRADY SMITH</u>		DATE SIGNED <u>11/5/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 7. 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Mem. Park Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HENRY SANDER & SONS, INC.</u>		24a. REC'D BY REGISTRAR <u>NOV 8 1957</u>	
ADDRESS <u>Baltimore Md.</u>		24b. REGISTRAR'S SIGNATURE <u>L. G. Deall</u>	

MEDICAL CERTIFICATION

11467

Reg. Dist. No.

21

CERTIFICATE OF DEATH

Item 6, Film G222, 11/22/57 fcy

11461

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewater,</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> <u>x2 Edgewater,</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>at home of Rt 1 Box 273 C Selly on the Bay</u>		d. STREET ADDRESS <u>1 Rt 1 Box 273 C Selly on the Bay</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>David</u> Middle <u>Park</u> Last <u>Park</u>		4. DATE OF DEATH Month <u>November</u> Day <u>16</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>CHINESE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 2, 1957</u>
9. AGE (In years last birthday) <u>13</u>		IF UNDER 1 YEAR Months <u>13</u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Park, Chung Soo</u>		14. MOTHER'S MAIDEN NAME <u>Lee, Bum Joon</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Father</u>		Address <u>1701 Park Rd. NW, Washington D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>925.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>30 minutes?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>child was found in death in his crib by Mrs. Dempsey who is foster parent</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>9</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Rt 1 Box 273 C Edgewater</u>		20f. (City or town) (County) (State) <u>A. A Md.</u>	
21. I certify that I attended the deceased from <u>Nov. 16</u> , 19 <u>57</u> , to <u></u> , 19 <u></u> , that I last saw the deceased alive on <u>12</u> , and that death occurred at <u>5:40 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Sylvia M. Lin</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>Rt 1 Box 277-M Edgewater, Md. 11-16-57</u>	
PHYSICIAN'S NAME (Type) <u>Sylvia M. Lin</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-16-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John Hopping</u>		24a. REC'D BY REGISTRAR <u>Nov 18 1957</u>	
HOPPING FUNERAL HOME <u>Annapolis, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Thm. French</u>	

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11468

11409

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Sanitis Nursing Home</u> <u>Millersville</u> <u>Ad. Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> <u>103 Best Gate Rd.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis md.</u>	c. LENGTH OF STAY IN 1b <u>5 mo.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Best Gate Rd. P.F.D. Annapolis Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Acile Rd.</u>		d. STREET ADDRESS <u>103 Best Gate Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Rose</u> Middle <u>E.</u> Last <u>Pindell</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>9</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept-7-1901</u>
9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Lamb</u>		14. MOTHER'S MAIDEN NAME <u>Carrie</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Dorothy Smith - Daughter</u>		Address <u>none</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lobar Pneumonia</u> <u>490X</u> DUE TO <u>Cerebral Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <u>Hemiplegia (left) Residuals</u> (b) <u>Residuals</u> (c) <u>Residuals</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>4 months</u> <u>3 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Nov 8-57</u> , 19 <u>57</u> , to <u>Nov 9-57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Nov 8-57</u> , 19 <u>57</u> , and that death occurred at <u>8:00</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph Lipskey</u>		DATE SIGNED <u>Nov 19-57</u>	
PHYSICIAN'S NAME (Type) <u>JOSEPH LIPSEY</u>		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11-12-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Glendora Court</u>	22d. LOCATION (City, town, or county) (State) <u>Blon Burnell, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u>		24a. REC'D BY REGISTRAR <u>NOV 12 1957</u>	
ADDRESS <u>Annapolis, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>A. M. Joyce</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION		6. PLACE OF BIRTH		7. DATE OF DEATH		8. TIME OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
JAMES EARL RAY		M		35		W		None		Memphis, Tenn.		April 4, 1968		4:30 PM		Shot		Suicide		[Signature]		[Signature]	
13. PLACE OF DEATH		14. COUNTY		15. CITY		16. STATE		17. ZIP CODE		18. MEDICAL EXAMINER		19. CORONER		20. FUNERAL HOME		21. BURIAL PLACE		22. DATE OF BURIAL		23. TIME OF BURIAL		24. REMARKS	
St. Louis, Mo.		St. Louis		St. Louis		Mo.		63101		None		None		None		St. Louis		April 4, 1968		4:30 PM		None	

BUREAU V. S.

NOV 12 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 13, 14 Film G223 11-29-57 et

CERTIFICATE OF DEATH

1146928

Reg. Dist. No.

11462

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville, Md.		c. LENGTH OF STAY IN 1b 3ys, 6mo, 11da.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		d. STREET ADDRESS 3113 Normount Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Charles Middle Porter Last Porter		4. DATE OF DEATH Month 11 Day 18 Year 19 57	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 4/6/1873
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Hospital Record		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular Disease 023x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis and Syphilis DUE TO (c) ----- PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome associated with Arteriosclerosis 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. ----- 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 7 , 19 54 , to November 18 19 57 , that I last saw the deceased alive on November 18 19 57 and that death occurred at 4:55 A. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 11/18/57 ACTUAL SIGNATURE Ludwig Benedict, M. D. PHYSICIAN'S NAME (Type) Ludwig Benedict, M. D. Crownsville State Hospital, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF 11-21-57	
22c. NAME OF CEMETERY OR CREMATORY mt cuthbert		22d. LOCATION (City, town, or county) (State) md	
23. FUNERAL DIRECTOR'S SIGNATURE Geo. L. Nelson		24a. REC'D BY REGISTRAR NOV 25 1957	
ADDRESS 134871 Calhoun St		24b. REGISTRAR'S SIGNATURE H. M. Jones	

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11470

CERTIFICATE OF DEATH

Reg. Dist. No. 78

11463

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>Maryland</u> COUNTY <u>Anne Arundel</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY OR TOWN <u>Millersville</u>		LENGTH OF STAY (in this place) <u>1 mo.</u>		CITY OR TOWN <u>Millersville</u>		CITY OR TOWN <u>Glen Burnie</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sann's Nursing Home</u>				STREET ADDRESS (If rural give location) <u>401 Furance Branch Road</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>William</u>		(Middle) <u>A</u>		(Last) <u>PURKINS</u>		(Month) <u>11</u> (Day) <u>7</u> (Year) <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>Oct. 28-1884</u>	9. AGE last birthday <u>73</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Photo Engraver (ret.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Publicity Eng. Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George M. Purkins</u>				14. MOTHER'S MAIDEN NAME <u>Mary Heiderman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service) <u>---</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT & ADDRESS <u>Mrs. Vesta E. Purkins. Same as No. #2</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
443x IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive Cardio-vascular Dis.</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>9-30</u> , 19 <u>57</u> , to <u>11-6</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11-6</u> , 19 <u>57</u> , and that death occurred at <u>12:30</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>W. MacDonall M.D.</u> M.D.				DATE SIGNED <u>11-8-57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Nov. 11-1957</u>		NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cemetery</u>		LOCATION (City, town, or county) (State) <u>Glen Burnie, Maryland</u>	
24. REC'D BY REGISTRAR <u>A. M. Joyce</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>H. Singleton</u>		ADDRESS <u>Glen Burnie, Md.</u>	
DATE <u>NOV 12 1957</u>							

CERTIFICATE OF DEATH

Form No. 100-100

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

DATE OF DEATH
TIME OF DEATH

PLACE OF DEATH



BUREAU V. S.

NOV 12 1957

RECEIVED

TO BE FILLED BY THE REGISTRAR OF DEATHS
This certificate is to be filled out by the Registrar of Deaths, who is the official responsible for the registration of deaths in the Commonwealth of Massachusetts. It is to be filed in the office of the Registrar of Deaths, who is the official responsible for the registration of deaths in the Commonwealth of Massachusetts. It is to be filed in the office of the Registrar of Deaths, who is the official responsible for the registration of deaths in the Commonwealth of Massachusetts.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

11411

11471

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>AA</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>				c. LENGTH OF STAY IN 1b <u>ANNAPOLIS 10</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>A.A. GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>1739 FOREST DRIVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>F.</u> Last <u>ROBERTS</u>				4. DATE OF DEATH Month <u>11</u> Day <u>4</u> Year <u>1957</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/10/1889</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CIVIL SERVICE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u>		11. BIRTHPLACE (State or foreign country) <u>OHIO</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>JAMES F. ROBERTS</u>				14. MOTHER'S MAIDEN NAME <u>SARAH RINEHART</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>WWI + II</u>				16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT Address <u>Dorothy SKIPPER #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4343</u> <u>Cerebral Disease</u> DUE TO <u>Sudden</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u> </u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year <u>11-4-57</u> Hour <u>1:30</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>E. F. Roberts</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>E. F. Roberts</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11/7/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>NAVAL ACADEMY</u>		22d. LOCATION (City, town, or county) <u>ANNAPOLIS</u> (State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor & Sons</u> ADDRESS <u>Annapolis, Md.</u>				24a. REC'D BY REGISTRAR <u> </u> DATE <u>11/6/57</u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED _____ SEX _____ AGE _____ DATE OF BIRTH _____ PLACE OF BIRTH _____ OCCUPATION _____ MARITAL STATUS _____ PLACE OF DEATH _____ DATE OF DEATH _____ TIME OF DEATH _____ CAUSE OF DEATH _____ MANNER OF DEATH _____ SIGNATURE OF EXAMINER _____ OFFICE OF EXAMINER _____ COUNTY OF _____ STATE OF _____ DATE OF EXAMINATION _____ TIME OF EXAMINATION _____ PLACE OF EXAMINATION _____ SIGNATURE OF WITNESS _____ OFFICE OF WITNESS _____ COUNTY OF _____ STATE OF _____ DATE OF EXAMINATION _____ TIME OF EXAMINATION _____ PLACE OF EXAMINATION _____		NAME OF DECEASED _____ SEX _____ AGE _____ DATE OF BIRTH _____ PLACE OF BIRTH _____ OCCUPATION _____ MARITAL STATUS _____ PLACE OF DEATH _____ DATE OF DEATH _____ TIME OF DEATH _____ CAUSE OF DEATH _____ MANNER OF DEATH _____ SIGNATURE OF EXAMINER _____ OFFICE OF EXAMINER _____ COUNTY OF _____ STATE OF _____ DATE OF EXAMINATION _____ TIME OF EXAMINATION _____ PLACE OF EXAMINATION _____ SIGNATURE OF WITNESS _____ OFFICE OF WITNESS _____ COUNTY OF _____ STATE OF _____ DATE OF EXAMINATION _____ TIME OF EXAMINATION _____ PLACE OF EXAMINATION _____
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RECEIVED
 NOV 8 1957
 BUREAU V. S.

11464 CERTIFICATE OF DEATH

Reg. Dist. No.

2. DATE
OF
DEATH

II/3/57

1. NAME OF DECEASED
(Type or Print)

GEORGE M. SAUER

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION
Anne Arundel County
Curtis Creek4. USUAL RESIDENCE (Where deceased lived. If institution: residence
before admission)

A. STATE Md.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give
township)

Baltimore

D. STREET ADDRESS (If rural, give location)

Curtis Creek

c. Length of stay in Baltimore

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

W

8. DATE OF BIRTH

II/II/74

9. AGE (In years)

82

If Under 1 Year
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Operator

10B. KIND OF BUSINESS OR
INDUSTRY

B.T.C.

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

?

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

Family - Same

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic C.V. disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO
(C)II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.IF OPERATION WAS RELATED TO
CAUSE OF DEATH, ENTER IN
PART I OR PART II

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20. AUTOPSY?

YES ☐ NO ☐21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 19. 5th to
19. 57, that (I) (we) last saw the deceased alive on 19. 57,
and that death occurred at 6 A. m., from the causes and on the date stated above.

23A. SIGNATURE

Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. ADDRESS

M.D. 4700 Pennington Ave.

23C. DATE SIGNED

11/4/57

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

B

24B. DATE

II/7/57

24C. NAME OF CEMETERY OR CREMATORY

Glen Haven

24D. LOCATION (City, town, or county)

Baltimore

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

NOV 5 1957

McGul ly Funeral Homes - 130 E. Fort Ave.

THIS IS A PERMANENT RECORD. PLEASE TYPE, OR WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL-POINT PEN. Every item of information so carefully supplied. Physicians: please write the causes of death clearly and leg-
THIS CERTIFICATE MUST BE WITH THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER

RECEIVED

NOV 12 1957

BUREAU V. E.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11465

CERTIFICATE OF DEATH

Reg. Dist. No.

11473

1. PLACE OF DEATH o. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>A.A. Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL ANNAPOLIS</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL ANNAPOLIS XI</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SAVUS Nursing Home</u>				d. STREET ADDRESS <u>R.F.D. #3</u>			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>JOANNA</u> Middle <u>G.</u> Last <u>SHECKELS</u>				4. DATE OF DEATH Month <u>11</u> Day <u>28</u> Year <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-26-1903</u>	9. AGE (In years last birthday) <u>54</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>GEORGE GARNER</u>				14. MOTHER'S MAIDEN NAME <u>JOANNA ROCKHOLD</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT Address <u>FLOYD W. SHECKELS #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO (b) <u>Hypertension arterio-sclerotic</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>18 hr.</u> <u>37 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u> </u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8-30-54</u> , to <u>11-28-57</u> , that I last saw the deceased alive on <u>11-27-57</u> , 19 <u> </u> , and that death occurred at <u>2:58</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Frank M. Shipley</u> M.D.				ADDRESS (Street, city or town, state) <u>63 College Ave</u> DATE SIGNED <u>11-29-57</u>			
PHYSICIAN'S NAME (Type) <u>Frank M. Shipley</u>				ANNAPOLIS MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12-1-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>SALEM CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>ANNAPOLIS MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Rogers</u> ADDRESS <u>Annnapolis, Md.</u>				24a. REC'D BY REGISTRAR <u>12/2/57</u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF DECEASED	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11474

11412

CERTIFICATE OF DEATH

Reg. Dist. No.

21

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>A. A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>1 day</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel Gen Hosp</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Jennie Margaret Shepard</u>				4. DATE OF DEATH Month Day Year <u>Nov. 25 1957</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 30, 1907</u>	
9. AGE (In years last birthday) <u>50</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>John Allen Breunert</u>				14. MOTHER'S MAIDEN NAME <u>Molly White</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>MM</u>		17. INFORMANT Address <u>Husband Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hyperpyrexia</u> DUE TO <u>Cerebral hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive C. V. disease</u> DUE TO (c) <u>Hypertensive C. V. disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>6 hrs to</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>1956</u> , 19 <u>56</u> , to <u>Nov 25</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Nov 24</u> , 19 <u>57</u> , and that death occurred at <u>4:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Severna Park Md</u> DATE SIGNED <u>11-25-57</u> ACTUAL SIGNATURE <u>Robert R. Hahn</u> M.D. <u>Severna Park Md</u> PHYSICIAN'S NAME (Type) <u>Robert R. HAHN, Severna Park Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Nov 29 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GLEN HAVEN MEM PK</u>		22d. LOCATION (City, town, or county) (State) <u>GLEN BURNIE, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>George Rome 4001 Ritchie Hwy (25)</u>				24a. REC'D BY REGISTRAR DATE <u>12/2/57</u>		24b. REGISTRAR'S SIGNATURE <u>Am J. French</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>Dec 2, 1957</i>		5. TIME OF DEATH <i>10:00 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Myocardial Infarction</i>		8. MANNER OF DEATH <i>Natural</i>		9. MEDICAL HISTORY <i>None</i>	
10. SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i>		11. SIGNATURE OF DECEASED <i>John Doe</i>		12. SIGNATURE OF WITNESS <i>John Doe</i>	
13. SIGNATURE OF DECEASED <i>John Doe</i>		14. SIGNATURE OF WITNESS <i>John Doe</i>		15. SIGNATURE OF WITNESS <i>John Doe</i>	
16. SIGNATURE OF WITNESS <i>John Doe</i>		17. SIGNATURE OF WITNESS <i>John Doe</i>		18. SIGNATURE OF WITNESS <i>John Doe</i>	
19. SIGNATURE OF WITNESS <i>John Doe</i>		20. SIGNATURE OF WITNESS <i>John Doe</i>		21. SIGNATURE OF WITNESS <i>John Doe</i>	
22. SIGNATURE OF WITNESS <i>John Doe</i>		23. SIGNATURE OF WITNESS <i>John Doe</i>		24. SIGNATURE OF WITNESS <i>John Doe</i>	
25. SIGNATURE OF WITNESS <i>John Doe</i>		26. SIGNATURE OF WITNESS <i>John Doe</i>		27. SIGNATURE OF WITNESS <i>John Doe</i>	
28. SIGNATURE OF WITNESS <i>John Doe</i>		29. SIGNATURE OF WITNESS <i>John Doe</i>		30. SIGNATURE OF WITNESS <i>John Doe</i>	
31. SIGNATURE OF WITNESS <i>John Doe</i>		32. SIGNATURE OF WITNESS <i>John Doe</i>		33. SIGNATURE OF WITNESS <i>John Doe</i>	
34. SIGNATURE OF WITNESS <i>John Doe</i>		35. SIGNATURE OF WITNESS <i>John Doe</i>		36. SIGNATURE OF WITNESS <i>John Doe</i>	
37. SIGNATURE OF WITNESS <i>John Doe</i>		38. SIGNATURE OF WITNESS <i>John Doe</i>		39. SIGNATURE OF WITNESS <i>John Doe</i>	
40. SIGNATURE OF WITNESS <i>John Doe</i>		41. SIGNATURE OF WITNESS <i>John Doe</i>		42. SIGNATURE OF WITNESS <i>John Doe</i>	
43. SIGNATURE OF WITNESS <i>John Doe</i>		44. SIGNATURE OF WITNESS <i>John Doe</i>		45. SIGNATURE OF WITNESS <i>John Doe</i>	
46. SIGNATURE OF WITNESS <i>John Doe</i>		47. SIGNATURE OF WITNESS <i>John Doe</i>		48. SIGNATURE OF WITNESS <i>John Doe</i>	
49. SIGNATURE OF WITNESS <i>John Doe</i>		50. SIGNATURE OF WITNESS <i>John Doe</i>		51. SIGNATURE OF WITNESS <i>John Doe</i>	
52. SIGNATURE OF WITNESS <i>John Doe</i>		53. SIGNATURE OF WITNESS <i>John Doe</i>		54. SIGNATURE OF WITNESS <i>John Doe</i>	
55. SIGNATURE OF WITNESS <i>John Doe</i>		56. SIGNATURE OF WITNESS <i>John Doe</i>		57. SIGNATURE OF WITNESS <i>John Doe</i>	
58. SIGNATURE OF WITNESS <i>John Doe</i>		59. SIGNATURE OF WITNESS <i>John Doe</i>		60. SIGNATURE OF WITNESS <i>John Doe</i>	
61. SIGNATURE OF WITNESS <i>John Doe</i>		62. SIGNATURE OF WITNESS <i>John Doe</i>		63. SIGNATURE OF WITNESS <i>John Doe</i>	
64. SIGNATURE OF WITNESS <i>John Doe</i>		65. SIGNATURE OF WITNESS <i>John Doe</i>		66. SIGNATURE OF WITNESS <i>John Doe</i>	
67. SIGNATURE OF WITNESS <i>John Doe</i>		68. SIGNATURE OF WITNESS <i>John Doe</i>		69. SIGNATURE OF WITNESS <i>John Doe</i>	
70. SIGNATURE OF WITNESS <i>John Doe</i>		71. SIGNATURE OF WITNESS <i>John Doe</i>		72. SIGNATURE OF WITNESS <i>John Doe</i>	
73. SIGNATURE OF WITNESS <i>John Doe</i>		74. SIGNATURE OF WITNESS <i>John Doe</i>		75. SIGNATURE OF WITNESS <i>John Doe</i>	
76. SIGNATURE OF WITNESS <i>John Doe</i>		77. SIGNATURE OF WITNESS <i>John Doe</i>		78. SIGNATURE OF WITNESS <i>John Doe</i>	
79. SIGNATURE OF WITNESS <i>John Doe</i>		80. SIGNATURE OF WITNESS <i>John Doe</i>		81. SIGNATURE OF WITNESS <i>John Doe</i>	
82. SIGNATURE OF WITNESS <i>John Doe</i>		83. SIGNATURE OF WITNESS <i>John Doe</i>		84. SIGNATURE OF WITNESS <i>John Doe</i>	
85. SIGNATURE OF WITNESS <i>John Doe</i>		86. SIGNATURE OF WITNESS <i>John Doe</i>		87. SIGNATURE OF WITNESS <i>John Doe</i>	
88. SIGNATURE OF WITNESS <i>John Doe</i>		89. SIGNATURE OF WITNESS <i>John Doe</i>		90. SIGNATURE OF WITNESS <i>John Doe</i>	
91. SIGNATURE OF WITNESS <i>John Doe</i>		92. SIGNATURE OF WITNESS <i>John Doe</i>		93. SIGNATURE OF WITNESS <i>John Doe</i>	
94. SIGNATURE OF WITNESS <i>John Doe</i>		95. SIGNATURE OF WITNESS <i>John Doe</i>		96. SIGNATURE OF WITNESS <i>John Doe</i>	
97. SIGNATURE OF WITNESS <i>John Doe</i>		98. SIGNATURE OF WITNESS <i>John Doe</i>		99. SIGNATURE OF WITNESS <i>John Doe</i>	
100. SIGNATURE OF WITNESS <i>John Doe</i>		101. SIGNATURE OF WITNESS <i>John Doe</i>		102. SIGNATURE OF WITNESS <i>John Doe</i>	

BUREAU V. S.

DEC 3 1957

RECEIVED

Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11475

11466 CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH a. COUNTY <i>A.A.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>A.A.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bristol</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>xo Bristol</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>1</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Sarah Ida Simmons</i>		4. DATE OF DEATH <i>November 1 1951</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct. 14, 44 yrs.</i>
9. AGE (In years last birthday) <i>44</i>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Richard Sharps</i>		14. MOTHER'S MAIDEN NAME <i>Frances Thomas</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Richard Simon</i>		Address <i>Bristol, Ind.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Cardiac Failure</i> <i>416X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Rheumatic CV Disease</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>5 min</i> <i>15 yrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>June 1948</i> to <i>1 Nov 1951</i> , that I last saw the deceased alive on <i>31 Oct 1951</i> , and that death occurred at <i>5:24 AM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>RRB Danner</i>		M.D. <i>Hyper Marlboro, Md</i> DATE SIGNED <i>1 Nov 51</i>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>700-4-57</i>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <i>Prince Fred, Ind</i>		22d. LOCATION (City, town, or county) (State) <i>Bristol A.A. Ind</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>P.E. Sewell</i>		ADDRESS <i>Prince Fred, Ind</i>	
24a. REC'D BY REGISTRAR <i>11-5-51</i>		24b. REGISTRAR'S SIGNATURE <i>A.W. Ward</i>	
		<i>A.H. Roberts</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11467 CERTIFICATE OF DEATH

11476 28
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville, Md.		c. LENGTH OF STAY IN 1b 12ys, 4mo, 27da.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Springs, Md. 15x2.2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital, Md.		d. STREET ADDRESS Route 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Frances Middle Smith Last Smith		4. DATE OF DEATH Month 11 Day 10 Year 19 57	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/3/16
9. AGE (In years last birthday) 41 yrs.		IF UNDER 1 YEAR Months 4 Days 10 Hours 10 Min. 57	IF UNDER 24 HRS. Months 4 Days 10 Hours 10 Min. 57
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Willie Smith		14. MOTHER'S MAIDEN NAME Leona Jones	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) None		16. SOCIAL SECURITY NO. None	
17. INFORMANT Hospital Records		Address Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonitis 593x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute Renal Failure DUE TO (c) Spinal Tumor?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Psychosis with Mental Deficiency			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None		20f. (City or town) (County) (State) None	
21. I certify that I attended the deceased from June 14 , 19 45 , to November 10 , 19 57 , that I last saw the deceased alive on November 10 , 19 57 , and that death occurred at 8:40 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Lionel McHenry Mapp		ADDRESS (Street, city or town, state) Crownsville, Md.	
PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.		DATE SIGNED 11/12/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) None		22b. DATE THEREOF Nov 16/57	
22c. NAME OF CEMETERY OR CREMATORY Good Hope		22d. LOCATION (City, town, or county) (State) Crownsville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden		ADDRESS Rockville, Md.	
24a. REC'D BY REGISTRAR None		24b. REGISTRAR'S SIGNATURE None	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF WITNESS	
JAMES H. HARRIS		MALE		45		WHITE		JAN 15 1912		BALTIMORE, MD		JAN 15 1967		BALTIMORE, MD		HEART DISEASE		NATURAL		JAMES H. HARRIS		JAMES H. HARRIS	
13. FULL ADDRESS		14. OCCUPATION		15. MARITAL STATUS		16. EDUCATION		17. RELIGION		18. PREVIOUS ILLNESS		19. PREVIOUS SURGERY		20. PREVIOUS TRAUMA		21. PREVIOUS DRUGS		22. PREVIOUS ALCOHOL		23. PREVIOUS TOBACCO		24. PREVIOUS OTHER	
1000 E. BALTIMORE AVE		CLERK		MARRIED		HIGH SCHOOL		METHODIST		NONE		NONE		NONE		NONE		NONE		NONE		NONE	
25. SIGNATURE OF REGISTRAR		26. SIGNATURE OF WITNESS		27. SIGNATURE OF WITNESS		28. SIGNATURE OF WITNESS		29. SIGNATURE OF WITNESS		30. SIGNATURE OF WITNESS		31. SIGNATURE OF WITNESS		32. SIGNATURE OF WITNESS		33. SIGNATURE OF WITNESS		34. SIGNATURE OF WITNESS		35. SIGNATURE OF WITNESS		36. SIGNATURE OF WITNESS	
JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS	

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NOV 18 1967
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

Items 13, 14, Film G223 12-12-57 et

CERTIFICATE OF DEATH

Reg. Dist. No.

11472

11468

1. PLACE OF DEATH a. COUNTY <i>aa</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>aa</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Drury</i>				c. LENGTH OF STAY IN 1b <i>1</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <i>1</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <i>Charles T Spriggs</i>				4. DATE OF DEATH Month <i>November</i> Day <i>20</i> Year <i>1957</i>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>Colored</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>6/29/03</i>	
9. AGE (In years last birthday) <i>54</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer-Farmer</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Tobacco</i>		11. BIRTHPLACE (State or foreign country) <i>md</i>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <i>Thomas Spriggs</i>				14. MOTHER'S MAIDEN NAME <i>Unknown</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>NO</i>				16. SOCIAL SECURITY NO.			
17. INFORMANT <i>Eva T Spriggs Drury, Letham P.O. Md.</i>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral vascular accident</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>arteriosclerosis</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. <i>11</i> p. m. 19 <i>57</i>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <i>November 19</i> , to <i>November 19</i> , that I last saw the deceased alive on <i>November 19</i> , and that death occurred at <i>12:10 P.M.</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Emily H. Wilson</i> M.D.				ADDRESS (Street, city or town, state) <i>Letham, Md.</i>			
DATE SIGNED <i>11/20/57</i>							
PHYSICIAN'S NAME (Type) <i>acting coroner</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				22b. DATE THEREOF <i>11/24/57</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Moses</i>	
22d. LOCATION (City, town, or county) <i>DRURY MD</i>				(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Bernard Hardisty</i>				ADDRESS <i>Galesville Md</i>		24a. REC'D BY REGISTRAR <i>DEC 2 1957</i>	
24b. REGISTRAR'S SIGNATURE <i>J. French</i>							

STATE OF MARYLAND—BALTIMORE, 18

DEC 2 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11469

CERTIFICATE OF DEATH

Reg. Dist. No.

11478

1. PLACE OF DEATH a. COUNTY <i>D. C. C.</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <i>W. Va</i> b. COUNTY <i>Mineral Co.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pasadena</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>x2 Piedmont, W. Virginia</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>#15 Sanders Rd.</i>				d. STREET ADDRESS <i>#4 Green St</i>			
3. NAME OF DECEASED (Type or print) First <i>Thomas</i> Middle <i>Porter</i> Last <i>Swann</i>				4. DATE OF DEATH Month <i>11</i> - Day <i>14</i> - Year <i>1957</i>			
5. SEX <i>M.</i>	6. COLOR OR RACE <i>Wh.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1880-12-14</i>	9. AGE (In years last birthday) <i>76</i> yrs.	IF UNDER 1 YEAR Months <i>76</i> Days <i>76</i> Hours <i>76</i> Min.	IF UNDER 24 HRS. Months <i>76</i> Days <i>76</i> Hours <i>76</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Coal miner - ret.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Coal</i>		11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <input checked="" type="checkbox"/>	
13. FATHER'S NAME <i>Thomas Swann</i>				14. MOTHER'S MAIDEN NAME <i>Mary Fitzgentry</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>236-03-3917</i>		17. INFORMANT <i>Family</i> Address <i>15 Sanders Rd. Pasadena Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Acute Cardiac Collapse</i> <i>154X</i> DUE TO <i>CA of Rectum & Metastases</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>5yr</i> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <i>1 da</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work <i>4/25</i>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>16</i>	
20f. (City or town) <i>CP</i>				20g. (County) <i>Mineral</i>		20h. (State) <i>W. Va</i>	
21. I certify that I attended the deceased from <i>11/14</i> , 19 <i>57</i> , to <i>11/14</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>11/14</i> , 19 <i>57</i> , and that death occurred at <i>6 P.M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Joseph G. Lawkaitis</i>				DATE SIGNED <i>11/14/57</i>			
PHYSICIAN'S NAME (Type) <i>JOSEPH G. LAWKAITIS MD</i>				ADDRESS (Street, city or town, state) <i>679 Washington Blvd Baltimore Md</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>11-18-57</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Phyllos</i>		22d. LOCATION (City, town, or county) (State) <i>Wadeport Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>McCully Funeral Homes</i>				24a. REC'D BY REGISTRAR <i>DATE 11-21-1957</i>			
ADDRESS <i>Balto. Md.</i>				24b. REGISTRAR'S SIGNATURE <i>L. J. Sealey</i>			

BUREAU V. S.

NOV 21 1957

RECEIVED

11470

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel Co</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) p. STATE <i>So. 56 B. Road 1 -</i> b. COUNTY <i>Glen Burnie. A. A. Co</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glen Burnie.</i>		c. LENGTH OF STAY IN 1b <i>acc to life</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Grace</i> Middle <i>Lillian</i> Last <i>Jeppes</i>		4. DATE OF DEATH Month <i>November</i> Day <i>22</i> Year <i>1957</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct 4, 1897</i>
9. AGE (In years last birthday) <i>60</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	
11. BIRTHPLACE (State or foreign country) <i>Bach. Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Phillip Emge</i>		14. MOTHER'S MAIDEN NAME <i>Sophia Stumler</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>No</i>	
17. INFORMANT <i>Paul Jeppes</i>		Address <i>Same as 2</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>096.9</i> <i>Cardio-Vascular Disease</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Acute Virus Infection</i> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>10 years</i> <i>5 days</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. — 19 p. m. —	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>1947</i> to <i>Nov 22</i> , 1957, that I last saw the deceased alive on <i>November 21</i> , 1957, and that death occurred at <i>5 A.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>108 Central Ave Glen Burnie Md</i> DATE SIGNED <i>Nov 22, 1957</i>			
ACTUAL SIGNATURE <i>James S. Billingslea</i> M.D.			
PHYSICIAN'S NAME (Type) <i>James S. Billingslea M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>11/25/57</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Glen Haven Memorial</i>	22d. LOCATION (City, town, or county) (State) <i>Glen Burnie, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>James H. Hopping</i>		24. REC'D BY REGISTRAR <i>NOV 25 1957</i>	
ADDRESS <i>Hopping and Kirkley, Glen Burnie, Md.</i>		24b. REGISTRAR'S SIGNATURE <i>L. J. Bellamy</i>	

MEDICAL CERTIFICATION

TO MAYOR OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with page 3 and be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, time, place, and cause of death. The form is divided into several horizontal sections with labels for each field.

BUREAU V. S.

NOV 25 1957

RECEIVED

11413

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

1. PLACE OF DEATH a. COUNTY <u>A. A. County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>A. A. County</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	c. LENGTH OF STAY IN 1b	e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>xomays</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		f. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Herbert M. Thomas</u>		4. DATE OF DEATH Month <u>11</u> Day <u>8</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B. DATE OF BIRTH <u>7-1-1929</u>	9. AGE (In years last birthday) <u>28</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>?</u>	11. BIRTHPLACE (State or foreign country) <u>Mayo Md</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Marshall Thomas</u>		14. MOTHER'S MAIDEN NAME <u>Sadie Cook</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>1-5-1951-12-14-56</u>		16. SOCIAL SECURITY NO. <u>217-24-9935</u>	
17. INFORMANT <u>Marshall Thomas Mayo Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Compound Fracture Skull</u> 825X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>?</u> DUE TO (c) <u>?</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>?</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERNAL BETWEEN ONSET AND DEATH <u>?</u>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident</u>	
20c. TIME OF INJURY Hour <u>PM</u> Month <u>11</u> Day <u>8</u> Year <u>57</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>	20f. (City or town) (County) (State) <u>ANSCO Md</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. Linhardt</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. Linhardt</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-11-1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mayo</u>		22d. LOCATION (City, town, or county) (State) <u>Mayo Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Bennett</u>		24a. REC'D BY REGISTRAR <u>NOV 12 1957</u>	
ADDRESS <u>108 Wash. St. Annapolis</u>		24b. REGISTRAR'S SIGNATURE <u>Tom Lynch</u>	

BUREAU V. S.

NOV 12 1957

RECEIVED

INSTRUCTIONS

1 The law requires that the death certificate be executed within 24 hours after death. The burial or cremation may be retained by the hospital or attending physician.

2 The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11481

11471

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ANNE ARUNDEL</u> MARYLAND		STATE <u>Maryland</u> COUNTY <u>Anne Arundel</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY OR TOWN <u>Glen Burnie</u>		LENGTH OF STAY (in this place)		STREET ADDRESS		(If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1221 Wilson Road</u>				STREET ADDRESS <u>1221 Wilson Road-Glen Burnie, Md.</u>			
3. NAME OF DECEASED (Type or Print) <u>NOAH OLIVER TRACY</u>				4. DATE OF DEATH (Month) <u>NOVEMBER</u> (Day) <u>8</u> (Year) <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Oct. 11, 1878</u>	9. AGE last birthday <u>79</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Rate Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Associated Transport</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Tracy</u>				14. MOTHER'S MAIDEN NAME <u>Mary Stevens</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Yes</u>		17. INFORMANT & ADDRESS <u>Glen Burnie, Md. Mr. Kenneth O. Tracy-405 3rd Ave. S.W.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
180x IMMEDIATE CAUSE (A) <u>Malignant Tumor of Kidney</u>						INTERVAL BETWEEN ONSET AND DEATH <u>8 mo</u>	
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Mar 1950</u> , 19....., to <u>11/8</u> , 19....., that I last saw the deceased alive on <u>11/3</u> , 19....., and that death occurred at <u>7 P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Bryant L. Jones</u>		M.D. <u>104 Chain Hoags Glen Burnie</u>		DATE SIGNED <u>11/8/57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>11/11/57</u>		NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cemetery</u>		LOCATION (City, town, or county) <u>Baltimore, Maryland</u>	
24. REC'D BY REGISTRAR <u>NOV 12 1957</u>		REGISTRAR'S SIGNATURE <u>L. J. Sealey</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Tucker</u>		ADDRESS <u>North Baltimore</u>	

CERTIFICATE OF DEATH

Reg. Civ. No.

AT NEURAL PATHOLOGICAL INSTITUTE OF MARYLAND

RESIDENT

JOHN ARNOLD

NOVEMBER 8 1937

TRACY

OLIVER

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8 sec

Midland Town of Kentucky

BUREAU V. S.

NOV 13 1937

RECEIVED

INSTRUCTIONS

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11482

11414

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH o. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ANNE ARUNDEL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS				c. LENGTH OF STAY IN 1b 7 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 ANNAPOLIS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USNH ANNAPOLIS, MD.				d. STREET ADDRESS 77 Shipwright Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CLAIRE Middle O'NEILL Last VOGEL				4. DATE OF DEATH Month NOV Day 16 Year 19 57			
5. SEX Female	6. COLOR OR RACE Cau	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 15 June 1945		9. AGE (In years lost birthday) 12 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY — — —		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME RAYMOND WILLIAM VOGEL				14. MOTHER'S MAIDEN NAME CLAIRE PATRICIA O'NEILL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — — —		16. SOCIAL SECURITY NO. — — —		17. INFORMANT USNH ANNAPOLIS, MARYLAND Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 491X IMMEDIATE CAUSE (a) DIFFUSE BRONCHOPNEUMONIA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) STAPHYLOCOCCUS AUREUS DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 5 Days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 15 Nov , 19 57 , to 16 Nov , 19 57 , that I last saw the deceased alive on 16 Nov , 19 57 , and that death occurred at 3:10A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) USNH ANNAPOLIS, MD. DATE SIGNED 11-16-57							
ACTUAL SIGNATURE <i>for Robert B. Weiss</i> M.D. USNH ANNAPOLIS, MD.							
PHYSICIAN'S NAME (Type) B. A. WEISS LT MC USNR							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-19-57		22c. NAME OF CEMETERY OR CREMATORY Naval Academy Cemetery		22d. LOCATION (City, town, or county) (State) Annapolis, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Don J. French</i> Hopping Funeral Home				ADDRESS Annapolis, Md.		24a. REC'D BY REGISTRAR NOV 19 1957	
						24b. REGISTRAR'S SIGNATURE <i>Don J. French</i>	

BUREAU V. S.

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RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11483

Reg. Dist. No.

11472

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <u>Georgia</u> b. COUNTY <u>Muscogee</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewater</u>		c. LENGTH OF STAY IN 1b <u>43 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Midland</u>		49 X - 3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5 Puddington Drive (Home)</u>		d. STREET ADDRESS <u>Route 1 Old Macon Rd.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Jefferson</u> Last <u>Wadkins</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>4</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 1st, 1892</u>
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Textile Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Textile</u>	
11. BIRTHPLACE (State or foreign country) <u>Alabama</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Franklin Wadkins</u>		14. MOTHER'S MAIDEN NAME <u>Florence Bennett</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>418-05-2104</u>	
17. INFORMANT <u>Maude B. Wadkins (wife), Edgewater</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, Hypostatic, Terminal.</u> <u>332 x</u> DUE TO (b) <u>Thrombosis, Cerebral.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Hypertensive, Arteriosclerotic disease.</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>1 week.</u> <u>5 years.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Brain Syndrome due to Cerebral Arteriosclerosis.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 22nd, 1957</u> , to <u>Nov. 4th, 1957</u> , that I last saw the deceased alive on <u>Nov 4th, 1957</u> , and that death occurred at <u>1.05 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>State Hospital</u> DATE SIGNED <u>Nov 4th, 57</u> ACTUAL SIGNATURE <u>Lionel McHenry Mapp</u> M.D. <u>State Hospital</u> PHYSICIAN'S NAME (Type) <u>Lionel McHenry Mapp, M.D.</u> <u>Crownsville</u> Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal-Burial November 5, 57</u>		22b. DATE THEREOF <u>Nov 5, 57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Lanett Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Lanett, Alabama</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOPPING FUNERAL HOME</u>		24. REC'D BY REGISTRAR DATE <u>NOV 7 '57</u>	
ADDRESS <u>Annapolis, Maryland</u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
NOV 7 1957
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11484

11473 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>aa</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>PA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MD40</u>		c. LENGTH OF STAY IN 1b <u>39 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 MAYO</u>	
		d. STREET ADDRESS <u>1</u>	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>OLLIE ALBERT WHEATLEY</u>		4. DATE OF DEATH Month Day Year <u>Nov 12 1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/29/88</u>
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Seaford, Delaware</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Charles Wheatley</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH Tulle</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>215-12-4368</u>	
17. INFORMANT Address <u>Laura Wheatley Mayo and</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>gen. arteriosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan.</u> , 19 <u>49</u> , to <u>Nov. 12</u> , 19 <u>57</u> that I last saw the deceased alive on <u>Nov. 5</u> , 19 <u>57</u> , and that death occurred at <u>1:50 PM</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Amos Garrett Blvd., Annapolis, Md.</u> DATE SIGNED <u>11/13/57</u>			
ACTUAL SIGNATURE <u>S. Borssuck</u> M.D.			
PHYSICIAN'S NAME (Type) <u>S. Borssuck, M.D.</u>		<u>Annapolis, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>11/16/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MAYO MEMORIAL</u>	22d. LOCATION (City, town, or county) (State) <u>MD40 and</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Buried Hardisty Garrett and</u> ADDRESS		24a. REC'D BY REGISTRAR DATE <u>11/15/57</u> 24b. REGISTRAR'S SIGNATURE <u>V. Ormish</u>	

BUREAU V. S.

NOV 18 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

11485

11474

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brooklyn 25</u>				c. LENGTH OF STAY IN 1b <u>4 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>411 Crosswell Rd.</u>				d. STREET ADDRESS <u>Same</u>			
3. NAME OF DECEASED (Type or print) <u>George First Middle Last</u> <u>George Rutherford Wicklein</u>				4. DATE OF DEATH Month <u>November</u> Day <u>16</u> Year <u>19 57</u>			
5. SEX <u>M.</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/4/92</u>	
9. AGE (In years last birthday) yrs. <u>65</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Blacksmith</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore, Md.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>George R. Wicklein</u>				14. MOTHER'S MAIDEN NAME <u>Susanne Hiss</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>215-01-2390</u>		17. INFORMANT <u>Mrs. Hazel Wicklein (wife)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardio Vascular Diseases</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Over 2 years.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>June 56</u> to <u>11/16/57</u> , 19____, that I last saw the deceased alive on <u>11/8/57</u> , 19____, and that death occurred at <u>12.45P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Glen Burnie, Md.</u> DATE SIGNED <u>11/17/57</u>							
ACTUAL SIGNATURE <u>Gustave H. Faubert, M.D.</u>				Glen Burnie, Md.			
PHYSICIAN'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-20-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore 25, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>McCully Funeral Home, 130 E. Fort Ave., Balto. Md.</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 20 1957</u>		24b. REGISTRAR'S SIGNATURE <u>J. A. Whitson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
6. PLACE OF BIRTH		7. PLACE OF DEATH		8. DATE OF DEATH		9. TIME OF DEATH		10. CAUSE OF DEATH	
11. MEDICAL HISTORY		12. PRESENT ILLNESS		13. TREATMENT		14. POST-MORTEM EXAMINATION		15. SIGNATURE OF PHYSICIAN	
16. SIGNATURE OF REGISTRAR		17. SIGNATURE OF WITNESS		18. SIGNATURE OF DECEASED		19. SIGNATURE OF NEXT OF KIN		20. SIGNATURE OF BURIAL OFFICIAL	

RECEIVED
BUREAU V. S.
NOV 20 1957

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11486

Reg. Dist. No.

11475

Item 9 Film G223 12-12-57 et

1. PLACE OF DEATH a. COUNTY <i>ANNE ARUNDEL</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Anne County</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>EAST PORT</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harwood Maryland</i> x2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>HARRISON</i> Middle <i>WILLIAMS</i> Last <i>WILLIAMS</i>		4. DATE OF DEATH Month <i>11</i> Day <i>23</i> Year <i>1957</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>colored</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Approx. 52 yrs.</i>
9. AGE (In years last birthday) <i>52</i>		10. IF UNDER 1 YEAR Months <i>52</i> Days <i>23</i> Hours <i>11</i> Min. <i>57</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <i>Maryland</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>Maryland</i>	
13. FATHER'S NAME <i>Thomas Williams</i>		14. MOTHER'S MAIDEN NAME <i>Alise Randall</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>212-14-3381</i>	
17. INFORMANT <i>Address</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Drowning</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>929.8</i> (c) <i>929.8</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Found Floating in Severn River</i>	
20c. TIME OF INJURY Month, Day, Year <i>UNKNOWN 19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>RIVER</i>		20f. (City or town) (County) (State) <i>EASTPORT-AA MD</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>R. S. Fisher</i>		M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <i>R. S. FISHER</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>11-27-57</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Brewer Hill</i>		22d. LOCATION (City, town, or county) (State) <i>Annapolis, Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>William R. Reed #108 Wash St Annapolis Md</i>		24a. REC'D BY REGISTRAR <i>DATE 12/2/57</i>	
		24b. REGISTRAR'S SIGNATURE <i>Thm J. French</i>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

DEC 3 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11415

CERTIFICATE OF DEATH

11487

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General</u>				d. STREET ADDRESS <u>R. R. # 2</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Shirley</u> Middle <u>Ann</u> Last <u>Woolford</u>				4. DATE OF DEATH Month <u>11</u> Day <u>24</u> Year <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-8-54</u>	9. AGE (In years last birthday) <u>3</u> yrs.	IF UNDER 1 YEAR Months <u>3</u> Days <u>3</u> Hours <u>3</u> Min. <u>3</u>	IF UNDER 24 HRS. Months <u>3</u> Days <u>3</u> Hours <u>3</u> Min. <u>3</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>James Woolford</u>				14. MOTHER'S MAIDEN NAME <u>VIRGINIA MAE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>MRS. H. SILLAMAN Annapolis</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Laryngo-Tracheitis</u> DUE TO <u>474x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Laryngo-Tracheitis</u> DUE TO (c) <u>Laryngo-Tracheitis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>24 hr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11-24</u> , 19 <u>57</u> , to <u>11-24</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11-24</u> , 19 <u>57</u> , and that death occurred at <u>8:20 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Clayton Norton</u> M.D.				ADDRESS (Street, city or town, state) <u>95 Cathedral St.</u>		DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>Clayton Norton Annapolis, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>Nov 27-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Burne A & Co 2nd</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard A. Zwick</u> ADDRESS <u>Glen Burne Md</u>				24a. REC'D BY REGISTRAR <u>DEC 2 1957</u>		24b. REGISTRAR'S SIGNATURE <u>M. J. French</u>	

BUREAU V. S.

DEC 2 1957

RECEIVED